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ABSTRACT

This manual is designed to address some of the basic problems of those who work in family planning education, and is based on the recurring questions and concerns of participants in a nationwide series of DHEW-sponsored family planning education and communication workshops. The manual proceeds chronologically, dealing first with the planning of a family education program and then with the selection, development and use of educational methods and materials. Each section contains relevant questions, and exercises and models where appropriate. The planning section contains a checklist tool for needs assessment. There is a planning model and a list of contraceptive facts for client education. The bibliography is arranged by subject matter and includes references to both client education and professional materials, as well as suppliers. (Author/NG)

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Practical Suggestions for Family Planning Education

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Preface

In view of increasing demands for family planning education services, the training of family planning health educators and strengthening of the education component of family planning programs is of critical importance to effectively operating agencies and clinics. During 1973-74, in response to such concerns, Koba Associates, Inc. conducted a series of workshops in four DHEW regions on Family Planning Education and Communication.

The workshops, conducted under contract to the Bureau of Community Health Services (DHEW), were attended by family planning personnel responsible for educational activities in federally funded clinics and agencies. Approximately 160 participants attended the workshops, with the workshop curriculum for each region being designed to meet the unique needs of participant programs.

Leading specialists in the fields of family planning education and communication conducted the workshops. Their presentations and question-and-answer sessions dealt with many of the urgent day-to-day problems facing family planning personnel throughout the country. The presentations of these specialists represent an important basis for the materials which are contained in this volume of *Practical Suggestions*.

We sincerely hope that *Practical Suggestions* will be a vehicle by which many of the important ideas developed at the various workshops can be shared with others who face the same problems and are committed to the same goals.

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1.0 Introduction

1.1 Scope and Applicability

"How can I convince my superiors that family planning education in the clinic deserves 20 minutes of a patient's time and a budget?"

Practical Suggestions is designed to speak to some of the basic problems shared by those who work in the field of family planning education. The manual is based upon the recurring questions and concerns of participants in a nationwide series of DHEW-sponsored Family Planning Education and Communication Workshops. Although participants in the four workshops were drawn from varied locales, clinic duties, and program backgrounds, their concerns in the areas of education program planning and materials and methods selection, development and use carried a common theme.

Participants discussed the various problems and obstacles to planning and implementing an in-clinic education program within the structure of already existing family planning programs. Time factors, staff cooperation, budgeting and evaluation were only a few of the concerns expressed. Questions about methods and materials were also numerous: —How can you effectively reach a high risk or target group? —What does a client need to know about reproduction, —about her method of contraception? —What is the most effective way to communicate that information? Within varying circumstances and specifications, such questions were expressed repeatedly.

While **Practical Suggestions** cannot deal with the individual conditions that are present in every family planning program, there are certain generic problems to which some of the ideas and information contained here may prove applicable. The key word is *practical:* Limited funds and staffing are facts of life. The focus is the "how to" approach—combining imagination with available resources to develop or improve your family planning education program.

1.2 Why Bother with Family Planning Education?

To most readers, this may seem an odd question with which to introduce a manual of this title and stated focus. However, it is a complex question and bears consideration from varying perspectives: How do you, your staff, or your program coordinators view the educational component of your program? Is it an important part of your program, or is it a low-priority, rather extraneous, component?

There are differing ways in which family planning education may be considered important, and, if need be, justified as important to those who may require convincing. It is often difficult to justify resource allocation to a need simply on the basis of "intuition." Consider, for example, family planning education as—

- **A human right.** A client has the right to know as much as possible about methods of birth control. There also exists a right to control one's own reproductive future, and the complex question of the definition of informed consent.
- **A health need.** Possessing family planning knowledge, whether it concerns reproduction, contraception or child-bearing, may be an important factor in meeting the health needs of clients.
- **A way to improve program cost-efficiency.** Consider the cost of providing an abortion to a client who has become pregnant through a contraceptive use-error. The cost of preventing that usage error through effective education is certainly less than that of the abortion procedure. Also, consider the number of problem-oriented visits which might be made unnecessary through simple yet effective education on annoying contraceptive side effects. This may not be the most "humanistic" approach to the importance of education, but a cost-effectiveness analysis may speak the language of dollars and cents that is so important to most family planning programs.

Throughout **Practical Suggestions** is the implicit assumption that in-clinic education is important and deserving of a high priority in family planning programs. This manual has been developed to offer ideas and information to assist you in meeting this important need.

1.3 How to Use Practical Suggestions

Although you may wish to read **Practical Suggestions** from beginning to end, the materials have been arranged to enable quick reference to particular sections or subjects. The manual proceeds chronologically, dealing first with the planning of a family planning education program and then with the selection, development and use of educational methods and materials.

Each section contains some of the relevant questions posed by workshop participants, and exercises and models are provided when applicable. The section on planning a family planning education program contains a checklist tool for needs assessment which helps the reader to analyze the capabilities, resources and priorities of an existing program. A planning model is included and, in the development section, a list of contraceptive facts illustrates the techniques for development of sound client education materials and methods. The bibliography is arranged by subject matter, includes reference to both client education and professional materials, and provides the names and addresses of suppliers.

Practical Suggestions has been designed to point the way for those interested in the improvement or development of a family planning education program by sharing with the reader some of those ideas which workshop participants found most helpful.

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2.0 Planning a Family Planning Education Program

2.1 Introduction

Education activities within a family planning clinic often have the appearance of haphazard afterthoughts to other services provided by the clinic. Even in programs in which a great deal of time and attention has been given to the education component, other factors often intervene to diminish or disorganize the educational efforts: Staff may have all they can do simply to deliver contraceptive services to clients. The clinic's physical plant may not have a location appropriate for educational activities. The client load may limit the time available or scheduling of educational sessions.

Such problems and others similar to them are shared by many family planning programs. Obviously, there is no panacea, but careful planning and organization may be able to improve or even overcome many seemingly adverse situations. Development of a written education program plan can provide a reference tool for implementation, progress analysis, staff cooperation and overall evaluation.

In-clinic client education is, or should be, integrally tied to the clinic's operation: An effective program will operate far beyond the realm of a one-shot counseling session or presentation. The entire experience of a client visit to a clinic should be an educational experience which includes not only the delivery of clear and consistent information to the client, but also a mechanism to ensure that the client has received, i.e., comprehended and assimilated, the delivered information. Client education should be a responsibility of every clinic staff member, whether that person is counseling, informing, reinforcing, or evaluating; whether that person be receptionist, physician, health educator or nurses' aide.

2.2 Problem Identification and Analysis

Identifying the problems that inhibit this type of comprehensive educational activity in your clinic can be a difficult task. A staff meeting, conducted in a non-threatening or -judgmental manner, often provides the best perspective. Input from various staff members of varying positions may provide new insights and possible solutions, and will certainly add to the cooperative effort needed to effectively implement any program. The staff member who handles phone calls, for instance, may have the most accurate picture of which problems are most prevalent and immediate among clients, and consequently, a good idea as to what a client education program might wish to accomplish.

Staff input is also necessary to determine the priority of clinic education problems. Inauguration of a specific topic in a client education program may, for example, first require staff training in that topic.

Client assessment of the clinic's problems is also essential, and may point out areas of concern completely unknown to the staff. If clients are provided with a non-judgmental suggestion vehicle through which to evaluate clinic needs, they can be invaluable indicators of problem areas.

The process of problem identification and analysis tends to take on an overly simplistic tone when spoken of in general terms. This is not to imply that the process is an easy one, but only to note that firm and definite identification of the real problems to be faced is a first and important step in education program planning.

2.3 Resource Identification and Use

Once problems have been identified, the next step is matching those problems with the resources that can resolve them. Again, though this might appear to be a simple process, the solutions can be complex. Almost all of us, given the opportunity to name a problem solving entity for a family planning education program, could supply a brief answer: More money. More money for increased staff, for written materials, for more recent audio-visuals and a new projector, for staff training, etc. However, foregoing fantasy, most programs are faced with a definite shortage of funds, and must substitute the priceless commodities of imagination and initiative for cash. For instance:

- **Make effective use of your program's in-house expertise.** Have your physicians or nurses give training sessions in contraceptive methodology to other staff members. Use the artistic, carpentry, or literary talents of your staff. Recognize and utilize the organizational, counseling or imaginative capabilities of staff members who may have previously been used only routinely.
- **Go to outside organizations and agencies for assistance.** Request materials, supplies, and technical assistance from other organizations such as the American Cancer Society, state or local health departments, Planned Parenthood, hospitals and VD programs. Cooperate with other social and health care agencies in assessing your target population's needs. Ask the school system for technical assistance in counseling or teaching skills.
- **Get help from the media.** Go to television stations and newspapers for assistance. You might get television exposure by organizing a panel discussion on information of local interest, asking local or national ad groups to work

with the TV station, or developing public service announcements for TV spots. You may be able to get newspaper exposure by writing a question and answer column to which readers could send in questions about sex, VD, contraception, etc., or by writing a local newspaper series on family planning. Writing a letter to the editor, paying for an advertisement, or asking the newspaper to cover a conference or other newsworthy event connected with your clinic will also focus attention on your program.

- **Communicate with other family planning clinics.** Other programs of similar size and situation may have "bright ideas" and be willing to share them. A program with a more developed education component may be able to provide succinct and practical advice on materials and methods to choose, or planning pitfalls to avoid.

- **Go to private sources for assistance.** Try private sources such as the Rockefeller Foundation, ARCA Foundation, the Playboy Foundation. Even wealthy individuals may be able to provide support. Materials developed with private funds include:

  – "Ten Heavy Facts About Sex" – Syracuse University
  – "Contraceptive Technology" – Emory University
  – "Case Histories" – Emory University
  – *Children's Television Workshop* – A seven million dollar health series sponsored by Exxon, Aetna Life and Casualty, the Corporation for Public Broadcasting, the R. W. Johnson Foundation, and others.

Also, drug companies will sometimes pay for conferences related to medical societies, medical schools or health departments. They may also lend movies and help with exhibits.

- **Make use of year-end funds.** Look for extra year-end funds in the budget and make tradeoffs. If you have not spent all of the funds in any line-item, put them into another line-item to be spent before the year's end. For example, if you budgeted $5,000 for outreach and only used $4,000, take the extra $1,000 and use it to purchase needed educational materials. You may be able to move extra line-item funds at the year's end to other line-items as long as you do not overspend your total budget.

  Also, look for year-end funds outside your own program. Possible sources are your Regional Office of DHEW, Planned Parenthood Training Centers, Coordinating Councils, and Planned Parenthood affiliates.

- **Re-evaluate your educational materials purchases.** Purchase educational materials from other family planning programs if possible. Examples of some good program-developed literature are: Emory University's "True to Life"

and "What's Happening?"; Syracuse University's "Protect Yourself from Becoming an Unwanted Parent," "Ten Heavy Facts About Sex," and "VD Claptrap"; Rocky Mountain Planned Parenthood's "So You Don't Want to Be a Sex Object" and "This Is You." Before purchasing, pool your order with those from other local programs in order to purchase in bulk. This will decrease your per unit cost, since the more you order, the less each copy costs.

If you use drug company literature, make sure it is simple, uniform and honest. Often drug company literature is too complicated for the client. The literature may also contradict what your doctors are telling the clients, which can cause confusion and lead to contraceptive misuse. Write to the drug companies to get materials free, and when you receive the sample literature, review it carefully for consistency, simplicity and honesty.

Excerpt, with permission, sections of other people's materials that are relevant to your program or clinic population. Providing the source is cited, many people will allow the use of portions of their work.

- **Reevaluate your budget.** While family planning education is not a game in which staff covertly cut into the overall program budget, some budgeting tricks may enhance your education budget in "robbing Peter to pay Paul" fashion: If you do not have a separate education line-item, use money from the supplies or equipment line-item for educational materials. Give yourself greater potential flexibility in the budget by combining supplies, equipment and educational materials in one category.

  As mentioned above, purchase materials in bulk, and shop around for bargains on supplies and equipment.

- **Other ideas.**
  - Develop an eye for "junk" that could be used for displays, posters, etc.
  - Organize a raffle where half the proceeds go to the clinic and half to the winner.
  - Ask public libraries to order and loan pertinent films to your project.
  - Request the help of state universities in media use, survey methodology, needs assessment, or other technical assistance. Inquire about using vacant facilities for workshops or training sessions.
  - Ask art schools for aid in art work and design.

Most of these suggestions require soliciting help from outside sources. You may be surprised at how much people are willing and able to assist you. Family planning is not the "taboo" topic that it was even ten years ago; consequently, we can now expect and receive help from a wide range of sources.

2.4 Educational Plan Development

Identifying resources and matching them to your problems is a preliminary step that must then be incorporated into the development of a feasible education plan.

Perhaps the most efficient way to organize such a plan is to take the problem-oriented "goal, objective, sub-objective" approach. By defining your overall program plan through a set of goals, you may find it easier to plan and coordinate activities that flow smoothly into an education program plan.

First, to define the terms.

- A **goal** is that change in a condition or behavior toward which program efforts are directed. A goal *must* include parameters of time and measurable effect. Attainment of a goal is dependent upon the accomplishment of program objectives and sub-objectives.

The following statement, for example, *cannot* by definition be considered a goal: "Our education program goal is to help women to have only the number of children that they desire." The target population is not defined, no time factor is mentioned, and the measurability of success is complicated, if not impossible. The sentiment is admirable, but, as a plan development device, the statement is nearly meaningless.

Alternately, the following statement meets the definition of a goal: "By January, 1976, every client leaving our clinic will know a minimum number of facts about her chosen method of birth control that the staff has determined necessary for her effective contraceptive use." This goal defines the target population (clinic clients), includes a time factor (by January, 1976), and sets up a way in which to measure attainment (either the client will know the facts, or she won't—an easily tested indicator).

Appropriate and workable goals are necessary to further planning in that the components of the goal—i.e., objectives and sub-objectives—must be drawn from the goal. Given the first example above, it would be nearly impossible to formulate concrete activities that would further progress toward goal accomplishment.

Objectives and sub-objectives, like goals, require a formal and structured definition in order to be meaningful:

- **Objectives** are the *specific,* shorter term, components of a program goal. Each component objective must be accomplished before the program goal can be attained. Like goals, objectives must be clear and specific. Objectives are dependent upon the attainment of sub-objectives.
- **Sub-objectives** are components of an objective. Again, precision is necessary. Each sub-objective must be accomplished before the objective can be attained.

Following is a model that stems from the second and correct goal example given above. As can be seen, even some of the sub-objectives could be said to have "sub-sub-objectives." Obviously, the process can continue *ad infinitum:* The major point is that plans can be made and followed by using this tool, and concrete accomplishments can be realized.

As a final note on the problem-oriented "goal, objective, sub-objective" process, it should be noted that, above all, goals must be realistic. There is obviously no point in defining unattainable goals and such a practice can only lead to staff discouragement and disillusionment with the planning process. Goals can be both modest and meaningful.

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Example of Goals, Objectives and Sub-Objectives

Goal

By January, 1976, every client leaving our clinic will know a minimum number of facts about her chosen method of birth control that the staff has determined necessary for her effective contraceptive use.

Objectives

a. Design Program

On December 1, 1974, the entire clinic staff will meet to discuss the contraceptive education program.

b. Train Staff

By December 20, 1974 all clinic staff will have been trained to implement and evaluate the contraceptive education program.

c. Implementation

On January 10, 1975, the contraceptive education program will be inaugurated.

d. Evaluation

In addition to the ongoing client evaluation, the education program will be evaluated at 6 month and yearly intervals.

Sub-Objectives

1. The staff will discuss and determine the 3-5 "basic" facts per method necessary for effective contraceptive usage.
2. Client evaluation of the staff's "basic" facts selection will be determined by questionnaire. If necessary, the facts will be revised to better meet client needs.
3. Areas of staff responsibility will be assigned.
4. Necessary adjustments to clinic procedure will be discussed and determined.
5. Staff training procedures, program implementation and evaluation will be outlined.

1. Staff will be sensitized to the need for the program and the relevance of the program goal.
2. Staff will be trained to probe and evaluate a client's level of knowledge about her contraceptive.
3. Staff will be trained to instruct a client in her 3-5 basic facts.

1. In a counseling session, each client will be informed of the basic contraceptive facts.
2. Before leaving the clinic, each client will be evaluated—orally, or by written form—as to her level of knowledge of her 3-5 basic facts.
3. If necessary, the contraceptive facts will be reviewed with the clients.
4. Each client will receive a simple wallet size card printed with the clinic phone number, name, and her contraceptive facts.

1. Entrance interviews for all returning clients will include an evaluation of the client's retention of her contraceptive facts.
2. A follow-up phone call or interview will be done to evaluate the contraceptive facts retention of those clients who did not return to clinic.
3. After 6 months, the total data collection will be examined, and if necessary, the program re-designed.
4. By January, 1976, a full evaluation of the contraceptive education program data will be complete.

2.5 Evaluation and Assessment of a Family Planning Education Program

Evaluation of your family planning education program can:

- Justify the existence, expansion or change of a program.
- Improve staff attitudes and behavior.
- Increase funding.
- Provide a description of what has been done and what you are going to do.
- Assess the outcome of education activities.

A clear appreciation of program goals will enable you to make data collection decisions more easily: This will provide a better idea of what type of data you require, and how, when and where to obtain it.

Obviously, evaluation of education programs means much more than counting the number of pamphlets distributed or community presentations made. The effectiveness of the family planning program itself is directly related to the effectiveness of the educational component of the program, and is thus measured in a similar manner.

Perhaps the most important evaluative index is the client population that you serve. Clients can contribute to program evaluation through a variety of feedback mechanisms:

- Before a client leaves the clinic, have her fill out a *short* (preferably checklist) reaction form to clinic procedures, education and staff. Such a questionnaire should be absolutely neutral, leaving the client free to respond in as open and honest a fashion as is possible.
- Give clients a prepaid mail-in reaction form. The return rate will be small, but those that do come in can be valuable. You pay postage only on those forms that are returned.
- Conduct a post-exam session, and ask clients to describe their contraceptive methods. Check for gaps in information or uncertainty about the method's use.
- Make available and publicize an anonymous consumer complaint mechanism.
- Check the wastebaskets in and outside the clinic to see if your clients are throwing away written materials.

Another source of feedback can be a Consumer Advisory Council and/or other consumer groups.

- Have the group review educational materials and make suggestions. This can be an inexpensive pretest for

samples and can prevent wasting money on purchasing or developing ineffective materials (e.g., rent a film and try it out before you buy it. Request samples of educational materials and get reactions before you order in bulk.)

- Have the group observe the clinic in operation to get feedback on clinic procedures. You might have several members go through the clinic as clients and report back about staff and clinic operations.
- Have the group review counseling methods.
- Ask the group what services they would like to see improved, added or eliminated from the clinic.

Clinic staff can also provide valuable evaluation:

- Evaluate education sessions and counseling sessions. Have a staff member sit in on the education sessions and record what is said about each method and other areas covered. Look for gaps in information and for counselor-client rapport. Compare this with what the client retains in the post-exam session.
- Develop questionnaires for the staff regarding staff-client attitudes and clinic procedures.
- Have a suggestion/complaint mechanism available to the staff, and review the suggestions regularly.
- Hold staff meetings often to promote open discussion of current and planned clinic activities. Get input from *all* staff members.

Evaluation is a crucial component of family planning education. Without it, it is nearly impossible to determine what educational plans require improvement, maintenance, or elimination. Knowing what's effective and what isn't can only be accomplished by thorough evaluation and assessment of your educational program.

2.6 Family Planning Education Program Checklist

The following checklist is intended as a tool for program analysis. Although the questions and categories do not include every aspect of education program planning, they provide the framework through which one can organize and assess program capabilities, resources and needs. Often, such analysis offers a new perspective to the person who is otherwise immersed in the day-to-day workings of a program.

After completing the checklist, you may find it easier to formulate your plans for improving or developing an in-clinic client education program. Given the organization that this checklist provides, it will be easier to pinpoint and act upon those factors which may hinder or help the education program in your clinic.

Family Planning Education Program Checklist

Administrative Structure of a Family Planning Education Program

1. Is there an annual program plan for in-clinic client education: ☐ yes ☐ no

2. What are the components of this plan?
   - (a) Staff training ☐
   - (b) Program content ☐
   - (c) Staff assignment ☐
   - (d) Time allocation ☐
   - (e) Target groups ☐
   - (f) Media choice ☐
   - (g) Ongoing evaluation ☐
   - (h) Final evaluation ☐

3. Are there monthly work plans? ☐ yes ☐ no

4. Are there job descriptions for each staff position? ☐ yes ☐ no

5. What is contained in the job description for each position?
   - (a) Job function ☐
   - (b) Job duties ☐
   - (c) Scope of authority ☐
   - (d) Relationship between the position and other clinic positions ☐
   - (e) Responsibility to client ☐

6. What type of job mobility exists?
   - (a) Career ladder ☐
   - (b) Merit system ☐
   - (c) Available positions filled by staff ☐

7. What is the ratio of staff to clients?
   _____

8. What is the ethnic composition of the staff in comparison to population being served?
   _____
   _____
   _____

9. What positions are understaffed?
   - (a) Outreach ☐
   - (b) R.N. ☐
   - (c) L.P.N. ☐
   - (d) Health Aide ☐
   - (e) Clerical ☐
   - (f) Physician ☐
   - (g) Social Worker ☐
   - (h) Health Educator ☐
   - (i) _____ ☐

10. What are the reasons for these positions being understaffed?

_____

_____

_____

_____

Program Goals, Objectives and Sub-Objectives

Definitions:

Goal: A program goal is that change in a condition or behavior toward which program efforts are directed. A goal *must* include parameters of time and measurable effect. Attainment of a goal is dependent on the accomplishment of the program objectives and sub-objectives.

For example: By January, 1976, every client leaving our clinic will know a minimum number of facts about her chosen method of birth control that the staff has determined necessary for her effective contraceptive use.

Objectives: Objectives are the specific, shorter term, components of a program goal. Each component objective must be achieved before the program goal can be attained. Like goals, objectives must be clear and specific. Objectives are dependent upon the attainment of sub-objectives.

For example: (a) Design program: On December 1, 1974, the entire clinic staff will meet to discuss the contraceptive education program. (b) Train staff: By December 20, 1974, all clinic staff will have been trained to implement and evaluate the contraceptive education program. (c) Implementation: On January 10, 1975, the contraceptive education program will be inaugurated. (d) Evaluation: In addition to the ongoing client evaluation, the education program will be evaluated at 6 month and yearly intervals.

Sub-Objectives: Sub-objectives are components of an objective. Again, precision is necessary. Each sub-objective must be attained before an objective is accomplished.

For example: (a) 1. The staff will discuss and determine the 3-5 "basic" facts per method necessary for effective contraceptive usage. 2. Client evaluation of the staff's "basic" facts selection will be determined by questionnaire. If necessary, the facts will be revised to better meet client needs. 3. Areas of staff responsibility

will be assigned. 4. Necessary adjustments to clinic procedure will be discussed and determined. 5. Staff training procedures, program implementation and evaluation will be outlined. (b) 1. Staff will be sensitized to the need for the program and the relevance of the program goal. 2. Staff will be trained to probe and evaluate a client's level of knowledge about her contraceptive. 3. Staff will be trained to instruct a client in her 3-5 basic facts. (c) 1. In a counseling session, each client will be informed of the basic contraceptive facts. 2. Before leaving the clinic, each client will be evaluated —orally, or by written form—as to her level of knowledge of her 3-5 basic facts. 3. If necessary, the contraceptive facts will be reviewed with the client. 4. Each client will receive a simple wallet size card printed with the clinic phone number, name, and her contraceptive facts. (d) 1. Entrance interviews for all returning clients will include an evaluation of the client's retention of her contraceptive facts. 2. A follow-up phone call or interview will be done to evaluate the contraceptive facts retention of those clients who did not return to the clinic. 3. After 6 months, the total data collection will be examined, and, if necessary, the program is redesigned. 4. By January, 1976, a full evaluation of the contraceptive education program data will be complete.

With the above definitions and examples in mind, the following questions can be answered:

1. Have education program goals, objectives and sub-objectives been established? ☐ yes ☐ no

2. Indicate whether the following factors were considered in developing the goals, objectives and sub-objectives for your program:

   (a) Definition of the target population
      1. characteristics ☐ yes ☐ no
      2. location ☐ yes ☐ no
      3. size ☐ yes ☐ no
   (b) Definition of the desired results of the program. ☐ yes ☐ no
   (c) Allotment of time for each program component and determination of relationships among components. ☐ yes ☐ no
   (d) Design of measurement tool to determine success. ☐ yes ☐ no

3. What are the *goals* of your education program?

4. What are the education program *objectives?*

5. What are the education program *sub-objectives?*

6. What are the major obstacles to attaining your education programs goals, objectives and sub-objectives?

7. Which staff members were involved in developing the education program goals, objectives and sub-objectives?

	Goals	Objectives	Sub-Objectives
(a) _____	☐	☐	☐
(b) _____	☐	☐	☐
(c) _____	☐	☐	☐
(d) _____	☐	☐	☐
(e) _____	☐	☐	☐
(f) _____	☐	☐	☐
(g) _____	☐	☐	☐

8. Through what means were the education program goals, objectives and sub-objectives developed?

	Goals	Objectives	Sub-Objectives
(a) Administrative directive (from outside your immediate program)	☐	☐	☐
(b) Administrative directive (from within your immediate program)	☐	☐	☐
(c) Health educator's directive	☐	☐	☐
(d) Staff meetings	☐	☐	☐
(e) Random staff suggestions	☐	☐	☐
(f) Staff-consumer meetings	☐	☐	☐
(g) Advisory Board	☐	☐	☐
(h) Requests by outside source	☐	☐	☐
(i) _____	☐	☐	☐

9. Are the education program objectives and sub-objectives periodically reviewed and updated to meet your program goals? ☐ yes ☐ no

Staff Training

1. What types of staff training are part of the family planning education program?
   - (a) Pre-service training ☐
   - (b) On-the-job training ☐
   - (c) Supplemental formal training ☐

2. What staff members attend training sessions?

	Pre-Service Training	On-the-Job Training	Supplemental Formal Training
(a) Aide	☐	☐	☐
(b) Clerical Worker	☐	☐	☐
(c) Director, Administrator	☐	☐	☐
(d) Health Educator	☐	☐	☐
(e) L.P.N.	☐	☐	☐
(f) Outreach Worker	☐	☐	☐
(g) Physician	☐	☐	☐
(h) R.N.	☐	☐	☐
(i) Social Worker	☐	☐	☐
(j) Technician	☐	☐	☐
(k) _____	☐	☐	☐

3. What topic areas are covered during training?

	Pre-Service Training	On-the-Job Training	Supplemental Formal Training
(a) Advances in medical technology	☐	☐	☐
(b) Client contact/referral/follow-up	☐	☐	☐
(c) Client education: topics, methods, materials	☐	☐	☐
(d) Client motivation	☐	☐	☐
(e) Contraceptive methods	☐	☐	☐
(f) Counseling and interviewing techniques	☐	☐	☐
(g) Family life education	☐	☐	☐
(h) Human sexuality	☐	☐	☐
(i) Job responsibilities	☐	☐	☐
(j) Nutrition	☐	☐	☐
(k) Population concerns	☐	☐	☐
(l) Use of education equipment and materials	☐	☐	☐
(m) Verbal/non-verbal communication skills	☐	☐	☐
(n) Other _____	☐	☐	☐

4. How often are staff training sessions held?

_____

_____

Is attendance required? ☐ yes ☐ no

If yes, of whom? _____

_____

5. What is the mechanism for staff follow-up after training?

(a) Weekly staff meeting ☐
(b) Periodic review sessions ☐
(c) Monthly staff meetings ☐
(d) Performance evaluation ☐
(e) _____ ☐

6. Which staff members seldom or never attend training sessions?

_____

_____

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Client Education

1. What are the client education activities during a clinic session?
   - (a) Group orientation ☐
   - (b) Group discussion ☐
   - (c) One-to-one interview ☐
   - (d) One-to-one counseling ☐
   - (e) Demonstration ☐
   - (f) Lecture ☐
   - (g) Film ☐
   - (h) _____ ☐

2. What are the client recruitment activities?
   - (a) Door-to-door outreach ☐
   - (b) Outreach in common meeting places ☐
   - (c) Community lectures ☐
   - (d) School lectures ☐
   - (e) Cooperation with other social service agencies ☐
   - (f) Health fairs ☐
   - (g) Booths ☐
   - (h) Telephone hot line ☐
   - (i) _____ ☐

3. What types of educational materials are used?
   - (a) Bulletin board ☐
   - (b) Clinic-developed handout or pamphlet ☐
   - (c) Display ☐
   - (d) Drug company literature ☐
   - (e) Film ☐
   - (f) Filmstrip ☐
   - (g) Flipchart ☐
   - (h) Model ☐
   - (i) Newsletter ☐
   - (j) Organization (e.g. Planned Parenthood) literature ☐
   - (k) Poster ☐
   - (l) Slide ☐
   - (m) Tape or cassette ☐
   - (n) TV/radio ad ☐
   - (o) Newspaper ad ☐

4. What topic areas are covered in client education?
   - (a) Abortion/abortion referral ☐
   - (b) Breast self-examination ☐
   - (c) Cancer in women ☐
   - (d) Child spacing ☐
   - (e) Childhood diseases ☐
   - (f) Contraceptive methods ☐
   - (g) Family life education ☐
   - (h) Fertility/infertility counseling ☐
   - (i) Human sexuality ☐
   - (j) Immunization ☐

(k) Nutrition ☐
(l) Pap smear ☐
(m) Patients' rights ☐
(n) Population concerns ☐
(o) Pregnancy testing ☐
(p) Prenatal care ☐
(q) Sterilization ☐
(r) Vaginal infections ☐
(s) VD testing/prevention ☐

5. What follow-up is done for client education?

_____

_____

Community Resources

1. What coordination has been achieved for the sharing of family planning services, education, and the production and use of educational materials between different community agencies and your program?

_____

_____

_____

_____

2. What coordination exists among local family planning agencies to promote and achieve improved services?

_____ _____

_____

Educational Materials

1. What mechanisms are used for evaluating educational materials?

(a) Consulting with client advisory group ☐
(b) Consulting with clinic advisory board ☐
(c) Staff review ☐
(d) Client review ☐
(e) No evaluation ☐
(f) Outside agency evaluation ☐
(g) _____ ☐

2. By what criteria do you select your educational materials?

_____

_____

_____

_____

Finance

1. What are the funding sources of your total program?
   - (a) Governmental funds ☐
   - (b) Private funds ☐
   - (c) In-kind services ☐
   - (d) Private donations ☐
   - (e) Fund raising activities ☐

2. Are these resources available specifically for the education component of the program? ☐ yes ☐ no

3. What other sources are available for financing educational activities?

_____

_____

4. What are the education program costs in your clinic?
   1. Staff (percentage of each staff member's time spent informing and educating clients) $_____
   2. Administrative costs $_____
   3. Consultant costs (staff training and program development) $_____
   4. Educational materials and supplies $_____
   5. Development and production costs $_____
   6. Travel and conference expenses $_____
   7. Total $_____

      Cost per client served $_____
      Cost per client visit $_____
      Cost per outreach visit $_____

5. Which areas in the education program appear to be underfunded?

_____

_____

Program Evaluation

1. How is your educational program evaluated?

_____

_____

2. What measures are used for evaluation?

_____

_____

_____

3. What are the evaluative feedback mechanisms for staff, client, and cooperating agencies?

	Staff	Client	Agencies
(a) Questionnaires	☐	☐	☐
(b) Suggestion forms	☐	☐	☐
(c) Discussions	☐	☐	☐
(d) Drop-out rates	☐	☐	☐
(e) Contraceptive adoption rates	☐	☐	☐
(f) Referral rates	☐	☐	☐
(g) Continuation rates	☐	☐	☐
(h) Knowledge/Attitude/Practice (KAP) Surveys	☐	☐	☐
(i) Method failure	☐	☐	☐
(j) Birth rate decline	☐	☐	☐
(k) _____	☐	☐	☐
(l) _____	☐	☐	☐

In examining the above organization and planning outline, you should be better able to identify problem areas. Patterns of information that develop may aid you in finding your program's weaknesses and strengths and in planning for your education program.

2.7 Questions and Answers About Planning a Family Planning Education Program

- *How Can a Budget for Education Be Designed?*

Some programs view supplies and equipment as the only aspects of education which can be budgeted; however, education expenditures go beyond this. In-clinic education can be broken down into two budget areas: Direct education expenses and indirect education expenses. By allowing for both total direct and indirect expenses, a program can budget accurately for education.

	True	False	Don't Know
An IUD must be put in or taken out by a doctor.	☐	☐	☐
☐ I learned this at the clinic.			
☐ I knew this before I came to the clinic.			
Some possible side effects of the pill which may go away after a few months are: weight gain, breast tenderness and nausea.	☐	☐	☐
☐ I learned this at the clinic.			
☐ I knew this before I came to the clinic.			
If you have had a hysterectomy (womb removed) you can't have sex.	☐	☐	☐
☐ I learned this at the clinic.			
☐ I knew this before I came to the clinic.			
Having a TL (your tubes tied) changes your nature as a woman.	☐	☐	☐
☐ I learned this at the clinic.			
☐ I knew this before I came to the clinic.			

Direct educational expenses might include display materials, posters, radio and TV spots, pamphlets, brochures, films, AV equipment, books, salaries of health educators, counselors, outreach workers, etc. The indirect educational expenses should include the proportion of each staff member's time spent in educational activities. The percentage of their salaries related to time spent on educational activities should be broken down for the educational budget. If consultants are hired for technical assistance, this should also be included, as should printing costs, supplies, and time spent on materials development.

- *What Are Some Effective Techniques to Evaluate a Client's Family Planning Information?*

Analysis of a questionnaire such as the one that follows will give you an indication of a client's misinformation and its source: whether the misinformation is a community myth or the result of poor teaching in the clinic. The sample below is from a study on client education in the Family Planning Clinic at Grady Hospital in Atlanta, Georgia.

- *How Can Staff Performance Be Evaluated?*

The following tools may be employed in evaluating the performance of different staff members.

- Peer evaluation—e.g., two peers and an outside facilitator.
- Written evaluation by a physician or nurse.
- Written or oral client evaluation.
- Director or supervisor evaluation.
- Role play among staff members. (Mock session followed by a discussion of effectiveness.)
- Noting the number of positive, neutral and negative statements delivered by the counselor during an interview or group session. (Note false reassurances about methods.)
- Determining the number of times the counselor encourages a client to talk.

Staff evaluation by peer review should be a participatory process in which:

- Staff members work together to determine respective job roles and responsibilities.
- Staff work together to develop a set of standards by which to measure the effectiveness of their activities.
- Staff periodically review and/or revise evaluative standards.
- Staff develop a written evaluation instrument standards sheet (e.g., have a sheet for ranking each standard and noting the number of times a standard is met per clinic session vs. the number of times it should have been met.)

- *How Can a Good In-Service Staff Training Program Be Developed?*

Training can result in an increase of knowledge and skills, a change in attitude, and most important, a change in behavior. Ongoing training is important for all staff members. The clinic professionals may not be the best trainers—they may be in a rut themselves. Other staff members may be able to contribute more concerning the realities of daily clinic activities.

To make staff training a participatory process for all those involved, you might follow these steps:

- Conduct a needs analysis.
- Design a training system—a yearly plan as well as specific session plans.
- Plan the training session carefully and run it according to plan (—where?—who will conduct the session?—what equipment will be needed?—when?).
- Self-evaluate by measuring yourself against the criteria established by the staff as a whole.
- Evaluate changes by questioning clients about staff performance, or simply observing staff behavior.

There are problems inherent in training programs. Training can influence what people can do on the job, but it can't determine what they do. Constraints in the real world can nullify training.

Set up your training objectives by writing them in concrete form: "After the training session, participants will be able to perform the following activities. . ."

• *How Do You Get Teenagers Interested in Utilizing Family Planning Services?*

In many communities it is beneficial both for teens' health and for community relations to provide comprehensive health services in teen clinics. Services could include dental care and general medical care as well as contraceptive services. When a teenager attends this kind of clinic, it helps eliminate some of the embarrassment or fear that some parents or teenagers may feel when attending a clinic offering only family planning services.

Be sure to schedule clinic appointment times convenient for teens, i.e., after school hours. Work to create a comfortable, informal and accepting atmosphere.

• *How Do You Go About Setting Up Teen Clinics?*

In *The Sexual Adolescent: Communicating with Teenagers About Sex*, Sol Gordon makes these points:

- Include teenagers on a consultant basis.
- Coordinate and integrate different kinds of services.
- Involve people in the community—businessmen, officials, civic leaders, etc.—in the planning stages of clinic programs.
- Define the program through needs expressed by the teenagers in the community.
- Secure the cooperation of parents if possible.

- Include males in the contraceptive education process, emphasizing that they have easy access to an inexpensive contraceptive that is effective both for birth control and VD prevention.
- Distribute information to the community regarding the clinic's services through pamphlets, notices and news media.
- Include teenagers on the staff as outreach workers to contact peers.

- *What Are Some Effective Techniques For Increasing Male Participation in Contraceptive Education Programs?*

To get men involved on a large scale in family planning requires a total reorientation of male attitudes towards sharing responsibility for fertility control.

Provide pamphlets directed specifically to men. "The View From Our Side" is published by Emory University in Atlanta and is available at bulk rates. Also, Rocky Mountain Planned Parenthood publishes a pamphlet for men called "The Combination."

Involve men in the clinic process: Suggest that they come with their partners to counseling sessions or group discussions.

Go out and meet men on their own turf—this may be less threatening than asking them to enter a clinic. Go outside the clinic where the husbands or boyfriends are waiting and talk to them there. Let women attending your clinic know that men are welcome and are encouraged to come.

You may also be able to involve men by providing condoms, giving education on methods, making vasectomy referrals and providing infertility services.

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3.0 Family Planning Educational Materials: Selection, Development and Use

3.1 Introduction

Good education materials can't substitute for an adequate family planning education program, but are an important component of the overall education plan. In this section, some guidelines for the selection and development of good educational materials are given, as well as some ideas on appropriate and effective materials use. The range of educational materials from pamphlets through films is covered, and the section includes basic yet essential information about bulletin boards, flip-charts, and other educational aids. Implicit throughout this section on materials selection, development and use is a consideration of educational methods, i.e., making the material an effective educational tool by carefully considering the subject matter, the medium, and the intended audience.

3.1.1 Advantages of Educational Materials

As a means of transmitting information, materials offer several advantages:

- **Standardized form.** Materials don't omit information or have bad days like people do.
- **Individualized learning.** Education can be more productive when learning takes place at the individual's own rate.
- **Transmission of information that is not easily verbalized.** For example, a series of pictures or a film illustrating diaphragm insertion may be better than any number of words.
- **Attention getting and reinforcing.** Effective use of media can attract and hold attention.
- **Broadening access to information.** Materials can provide access to the informational and educational developments of other organizations.
- **Durability.** This is an advantage of good *printed* materials. A pamphlet or brochure goes home with the client, and can provide an educational experience outside of the clinic. For some clients, an anxious clinic visit is not an ideal time to learn.

3.1.2 Guidelines for Good Educational Materials

The following guidelines should be considered when selecting or developing any type of educational material. It is vital that materials be previewed and periodically reviewed to see if they meet the following standards:

- **Is it applicable to your clinic population?** Age, race, economic status and reading level of your clinic population are just a few of the variables that should be considered in selecting any material. This is a *crucial* factor.
- **Has it been evaluated by clients?** As simple as this may sound, it is often neglected in materials choice. Staff perspective of the definition of a good educational material may be vastly different from client perspective.
- **Is it free of racial or sexual bias?** Materials that in any way patronize or demean any group should be avoided.
- **It is honest?** Does it give false reassurances about contraceptive side effects? Are the effectiveness figures correct? Are all options made available?
- **Is the information consistent?** Materials in your clinic should never conflict either with one another or with information transmitted verbally by staff members. For example, if your clinic policy is to deal with condoms and foam as "one" method, your materials should reflect this.
- **Is the information current?** Is your material on the pill up-to-date? Do you cover new techniques of tubal ligation and abortion? Do your materials mention any new contraceptives, such as IUDs or "mini-pills," that you might now offer? Also, material should refer to "physician and nurse-clinician" or simply "clinician" to allow for new trends in clinic care.
- **Is the objective clear?** Both content and usage should display a clear understanding of the purpose of the presentation.

Throughout this section, these guidelines will be repeated and more specifically stated as they apply to particular materials. Suggestions are included which illustrate the processes of selecting, developing and using educational materials according to these standards.

3.2 Selecting from Among Existing Family Planning Education Materials

A wide range of educational materials is now available to family planning programs, and the process of selection can be a confusing one. Many organizations and programs have developed

and marketed materials and the range of quality, applicability, and cost is wide. This section offers criteria and suggestions for selecting materials that add to the guidelines offered in Section 3.1: Depending upon the material needed and the educational objective to be met, more specific guidelines for selection may be necessary.

The availability of many materials can give access to educational expertise, technological developments and production techniques that would be difficult for a single program to achieve. Wise and informed choice of materials can offer many advantages; alternately, selection of the wrong materials for your needs can be an educational and financial disaster. For this reason, the primary factors in materials selection should be *preview* and *evaluation* prior to purchase.

3.2.1 Printed Materials

Before ordering, get samples and examine them carefully; the guidelines in Section 3.1 can help. Additionally, you might consider the following:

- Most suppliers will provide samples that can then be distributed among staff and clients. Even publications that are beautifully produced by reputable organizations should receive such examination: No matter how professional the pamphlet, brochure or flip-chart may be, it may not fit the specific needs of your particular population.
- In general, research indicates that written materials dealing with *one* subject are best received by clients. While an extensive brochure that lists the mechanism of contraceptive action, usage, efficacy and side effects of every contraceptive may be valuable to the client who is *selecting* a method, it is often confusing for the client who needs specific information about her chosen method.
- In printed materials, applicability is especially important as it relates to the reading level of your population. Paternalism or talking down is as much to be avoided as is over-complexity or medical jargon.

3.2.2 Visual Materials

The selection of models, mobiles, posters, flip-charts and other like materials is more limited. In addition to the standards for accuracy and applicability, the dimension of durability must also be considered here. Such materials should be of a quality to withstand handling and everyday use.

3.2.3 Audio-Visuals

The guidelines can also be used to evaluate films and other audio-visual materials, but by the very nature of their purchase and use, additional and more specific standards must also be met:

- Rent a film before buying, even if staff members have already previewed it. Plan for the arrival of the film and be ready to get client and staff evaluations of its quality and usefulness. Paying a few days rental to see how a film fits into your clinic's workings and philosophy can be a good investment. Many suppliers offer a free preview; others, if you decide to purchase the film, may credit rental fees toward the purchase cost.
- The inherent attention-getting capability of audio-visuals can be diminished by confusing treatment of an unfamiliar subject. Viewers should be able to identify with people and scenes, so avoid foreign films and those that use odd angles or fast pacing. The presentation should be simple and straight-forward.
- Consider, in advance, the use of the film over an extended time period. A film that relies heavily on faddish slang expressions, for example, may appear dated very quickly.
- Note the equipment that will be needed. No matter how good the audio-visual, the purchase of a new piece of equipment solely to show it is impractical. Many audio-visuals are available now in a variety of modes (16mm, 8mm, Super 8, cassette, slide-sound, etc.), so purchase with your present and future equipment needs in mind.
- If most of a film is valuable and applicable to your clinic, but a certain section(s) is not, consider cutting or adding to the film to fit your purposes. Splicing is not a complicated process, and can be used to update a film's style or information.

The selection of family planning education materials is a buyer's market. There are many excellent materials available that are applicable to varying ethnic, racial, age, and socio-ecnomic groups; that deal with contraception in a variety of ways (prescription v. over-the-counter methods, birth spacing v. birth prevention, etc.); and that speak to the needs of other special groups such as non-readers or those with medical problems. The Bibliography lists many excellent materials, and also includes other bibliographic sources and references that can, in turn, help you to select education materials wisely. The introduction to the Bibliography contains information on how to locate information by subject matter and material type.

3.3 Developing Family Planning Education Materials

Preparing educational materials for your own clinic can tailor the entire process of education to your specific needs. Materials carefully designed for your clinic population can meet high standards of applicability and effectiveness, yet can be as simple as a mimeographed instruction sheet or as sophisticated as a film.

The guidelines for good education materials that apply to selection also, of course, apply to development. Additionally, important factors must be the quality and cost of creating your own materials. The following section offers suggestions for programs with varying resources and capabilities. "How to" information is given, as well as ideas for new materials that can add to your education program.

3.3.1 Printed Materials

Tailoring printed materials to your program can be accomplished either by developing an entire publication or by supplementing or personalizing standardized materials (*always* with permission and credit). There are several types of publications that you might want to provide in your program that can be developed in either fashion:

- Develop a pamphlet to introduce the clinic to the client. Include a floor plan, a description of what will happen to the client at each step in the clinic process, or photos of clinic personnel. This type of simple publication can go a long way toward making a client feel comfortable.
- Print pamphlets which explain your clinic's procedure for pelvic exams, breast exams, pap smears, pregnancy, etc. A simple, straight forward explanation may relieve a lot of anxiety.
- Put out a clients' newsletter to explain changes or developments in the clinic, in contraceptive technology, and other health care news.
- Provide an emergency sheet for mothers, giving information on nutrition, first aid, emergency numbers and needed immunization for children.
- Have tear-off pads printed, showing simple line drawings of the female reproductive system. A clinician can then draw in an IUD, etc., in an explanation to the client. The reverse side might contain an illustration to explain the menstrual cycle.

- Print up an "educational diagnosis" form. This could include both subject matter (e.g., "needs explanation of pelvic exam," "has questions about tubal ligation," "seems concerned about the pill and cancer," etc.) that can be checked or filled in and the name or position of the staff member who has been given the responsibility for that subject area. The form can then either be made a part of the client's chart or given to her to carry through the clinic process. As the client goes through the clinic, each staff member seen checks the form to see if she/he has a specific educational responsibility to the client. If so, the staff member performs that educative function and evaluates the client's retention and understanding, noting it on the form. The form then becomes part of the client's permanent clinic record. Areas of responsibility should be determined at a staff meeting.
- Print a wallet-size "clinic calling card" for clients with the clinic's name, address, phone number and hours on it. On the back of the card, staff members might write the name of the client's contraceptive and the name of a person in the clinic whom she should contact concerning possible problems.
- Keep an eye open for articles you might want to reprint, with permission, from magazines, newspapers, or even talk-show transcripts. If possible, print or stamp the clinic's name, address and phone number on the reprint. Always credit the source.

In developing publications consider the following:

- "Cookbook" listings of all birth control methods should be avoided except to introduce a client to contraception.
- For method instructions, develop a separate piece for each method.
- Concentrate on short pieces on single subjects (VD, pregnancy testing, etc.) for other topics that the clinic covers.
- Give people what they like to read. Come as close as you can to their needs and reading habits. Note what types of magazines your clients bring into the clinic to read, and copy that format or style in an educational piece. Emory University's "True of Life" magazine, for example, was developed from a romance magazine model.
- Make the piece entertaining and interesting through inclusion of sketches or graphics. Art students may volunteer to work with you if they receive a credit line. Often media and graphic arts departments at schools or colleges are glad to help.

- Recycle good material (as determined by reader evaluation) in new forms. If your IUD pamphlet, for example, was well received, reprint it in new colors with new illustrations.
- Evaluate the effectiveness of your printed materials through a client advisory group or a sample of your clinic clients.

You may be able to substantially reduce your printing or production costs through the following suggestions:

- Leave plenty of time for proofing by several staff members. This can prevent costly errors and oversights.
- Use press-on letters to achieve professional quality at little expense. Such letters come in many different sizes and type styles and can be used for original copy, for a master for printing, or for a stencil for mimeographing. It's a good idea to buy in limited quantity or store them in cellophane envelopes because large size letters have a tendency to dry out and crack.
- Use mimeograph techniques. These are especially good for covers. You can type and draw on the stencil, or have an office duplicating company make a long lasting vinyl stencil out of a black-and-white drawing or photograph. Then run it off on a mimeograph machine on any color stock you want.
- The ditto technique is a low cost, low volume technique for information which is fast-changing or temporary in nature; i.e., bulletins, schedules, storyboards, memos, evaluations. Four or five colors can be run on the same sheet.
- Find a printer who will work with you to help cut costs. Ask for left-over colored stock and other printing material cost breaks. Also, you may be able to get a discount at art or teacher supply or graphic arts stores.
- Do most of the work yourself. If you are explicit, fewer mistakes are made by those who must interpret your directions.
- Test out your material in a small run before ordering a larger printing.
- Deal in volume. For example, use volume printing for a brochure on films. If the content will be updated but the cover can remain the same, don't put the date on the cover. Run off a large number of covers because printing in volume gives you the best price break. Then, as you update the inside information, just staple it into the cover.

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3.3.2 Visual Materials

When developing visual materials, such as bulletin or display boards, posters, flip-charts, or flannel boards, keep in mind the elements of a good visual:

- Unity of subject matter. A single concept or idea should be developed.
- Visual identification. A viewer must be able to recognize the object or message. In choosing the subject and representation for your educational materials, try to relate to your viewers' needs and previous experiences.
- Print or symbol legibility. Be sure your printing and symbols are easy to recognize and identify. This is a time when neatness and clarity are very important.
- Eye-catching approach. Use surprising colors that attract attention. Vary materials—mix burlap, cardboard, photographs, styrofoam cutouts, pipecleaners and different types of markers. Exaggerate the size and shape of letters and objects.

A bulletin or display board can be a cheap and easy way to convey information. Manufactured boards are not very expensive, and boards can be made of cork, wood, styrofoam, and fabric even more economically. In developing a bulletin or display board:

- Use a neutral color like grey or tan for the background.
- Use bright colors (red is particularly good) for important materials or words.
- Keep the layout simple, attractive and uncluttered.
- Confine the material to one or two ideas. Cluttering the board with an assortment of unrelated materials makes it uninteresting and difficult to read. For instance, chose a theme such as childhood immunization, the importance of follow-up visits, or contraceptive advances and stick to it.
- Use a variety of materials to attract attention. Extend some display elements out from the board. This can be done by mounting a picture or object on a small box and attaching the box to the board. Extend titles beyond the boundaries of the board to pull the viewer's eye into the main display. In addition to pictures, try displaying real objects such as a pill package.
- Use several lettering techniques. Letters can be cut out of paper, cloth, cardboard or wood. Yarn, rope, grasses, vines and wire can also be used as effective lettering materials. Be sure there is enough contrast between letters and background to maintain good legibility.

- Make the lettering bold and plain, and words easy to understand. Fancy scripts may look pretty but are often difficult to read.

For posters, the key word is *simplicity*. A poster is intended to remind and reinforce, not convey a large amount of information:

- Limit to *one* striking idea and as few words as possible. For example: *"PILL USERS: Call us if you get . . .* (name severe side effects)."
- Make the message understandable.
- When possible, use materials from other phases of a campaign, i.e., illustrations from a chart, leaflet or film. This coordination acts to reinforce a message.
- When using press-on letters or other appliqued materials, spray with clear acrylic so they won't rub off.

Flip-charts should illustrate and outline a presentation and must be legible for group work:

- Feature just one main idea per page.
- Make sure the drawings flow in sequence.
- Use lively colors.
- Draw legible and accurate figures that are easy to understand.
- Use simple, bold lettering of a few key words.
- Construct the flip-chart of sturdy materials: Don't use markers that will smear or paper that will yellow or tear easily.

Flannel or felt boards can also be used for supplementing or illustrating a presentation:

- Cut-outs should be bold, yet realistic enough to be understood.
- Inconspicuous pins or marks can be used as a guide on the board surface to keep the perspective and placement of cut-outs correct.
- To construct a flannel board, first cut a piece of plywood, wallboard or heavy cardboard to the appropriate size (for audiences up to 100, a 3′ x 3′ board is sufficient). Stretch a piece of rough-surfaced cloth such as flannel, felt, wool or burlap over the board and fasten it securely with staples or tacks. A rough-weave blanket in a dark or neutral color is ideal.

3.3.3 Audio-Visuals

Audio-visual materials are often considered complex materials to develop, yet there are simple audio-visual techniques that can be very effective. Again, development can either be total, or may be used to supplement other audio-visuals. For instance, you could produce a filmstrip or slide-sound presentation introducing your clinic personnel and procedures, or insert photographs of your own clinic and staff into a professionally done audio-visual. This personalizing touch can attract and hold attention.

When developing audio-visuals, remember:

- You don't need an expensive camera for most productions.
- Great photographic expertise is not required: Make the photos simple and close-up.
- Use the opportunity to increase the production's applicability by getting ideas from your clients. Before finalizing the presentation, have some of your clients or advisory council assess its effectiveness and use.
- Be sure to obtain the written consent of *all* persons who appear in the production. This precaution avoids many potential problems.

Filmstrips and slide-sound presentations are perhaps the easiest audio-visual to produce. To prepare materials for filmstrip production:

- Find a good filmmaking firm and get advice and instructions on how to put together materials for their final production job.
- Write the script and content outline, keeping in mind your audience and objective.
- Prepare illustrations to fit the content, using photographs, diagrams, charts or drawings.
- Copy the illustrations with a camera with a close-up attachment on negative or direct positive film. Any number of filmstrips can then be made from the negative.

There are several steps in preparing a slide-sound presentation.

- Gather the background materials and write the script, keeping in mind your audience and objective.
- Make up the slides after you have gone through the script and noted the points that need to be illustrated with slides. 35 mm slides are inexpensive to make.

- Use a story-board as an organizing tool. Set up one piece of paper for each slide, dividing it into four sections for a description of the slide or scene, directions for taking the picture, words associated with the slide from the script, and a description of the purpose of the slide and script.
- Record or read the script you have written. Low level background music will enhance the presentation.
- On the script, place a dot over the word with which the slide should change or synchronize the projector with a tape recorder.

3.3.4 Multi-Media Exhibits

For in-clinic use, local fairs or other presentations, a well-developed multi-media exhibit can be an attention getter. Be aware of community events that might welcome such an exhibit, and have the basic frame ready to be supplemented with appropriate materials. Use the exhibit in the clinic, changing the materials displayed to keep it current and interesting, and make use of it when giving group presentations either in the clinic or in the community. In developing exhibits:

- The frame should be portable, should assemble and dismantle fairly easily, and should be capable, literally, of standing alone. Department stores will often either give or lend you old displays and display racks, especially if you give them a credit line. When you take the exhibit out of the clinic for a presentation, don't count on finding supports or props. A hinged three-panel structure can be the basic unit, and shelves or other projections can then be attached for a three dimensional effect. Electrical wiring for the exhibit is not a complicated matter, and can allow the inclusion of a tape recorder or slide show.
- Combine media to fit your purpose. Use models, photographs, bulletin boards, posters and/or handouts with tapes, slides or films. For example, a display of photographs to attract attention; a simple demonstration to present information; a bulletin board to summarize the main points of the demonstration, and leaflets for a take-home reminder.
- Limit the exhibit to one central theme. Outside of the clinic, you might focus on clinic activities and services. When you use the exhibit in the clinic, concentrate on such themes as the breast self-exam, VD, or a health problem such as hypertension or sickle cell anemia.
- Use few words and place key illustrations or objects where they will be seen.

- Make the exhibit timely. Consider coordinating with local campaigns such as immunization programs.
- Label all parts of the exhibit that need an explanation.
- Make it durable. If printed materials are going to get a lot of use, have them printed on heavy cardboard.
- Make it attractive. Use bright colors, an unusual format, a large picture or catchy slogan. To hold attention, the exhibit must focus on the needs of the intended audience.
- If you include sample literature that you don't want to lose, number each publication. Have a numbered key or materials list available that people can refer to for the address and price. (Some people are just collectors, so think about what you're offering. With some items you might want to give a supplier's name and address.) But don't number everything—some things you should supply free. Ditto or mimeograph these.
- Involve local people. Use co-workers, teachers and students to help plan and build the exhibit. Have them present to answer questions and ask them to make a mental note of questions which might serve as ideas for future exhibits.

3.4 Appropriate Use of Family Planning Education Materials

Common sense will dictate appropriate and effective usage of most of the educational materials that have been mentioned in the previous sections. It can be assumed that intended use is of prime importance in the process of selecting or developing materials, and that factors such as applicability to the viewer and appropriate subject matter treatment are taken into consideration.

This section, then, concentrates on suggestions for more effective and innovative use of each materials category:

3.4.1 Printed Materials

- Use printed materials that coordinate with verbal presentations, posters, models or other materials. This aids in viewer identification and familiarity. Especially in clinic-developed materials, it should be a fairly simple task, for instance, to coordinate the ordering and wording of printed messages with the verbal messages delivered in counseling or other educational sessions. For example, all your printed materials and verbal messages should give totally consistent "how to take pills" instructions.
- Re-use and re-cycle good pieces of printed materials. If a section of a publication is valuable to you, obtain

permission to reprint it either for use by itself or for inclusion in your own publication. Salvage still-topical sections of your otherwise dated materials, either for independent use or for a basis for a new publication.

- When explaining a method(s) to a client, write on the printed instructions. These added notes may serve to individualize the instructions for her, and may help her to understand and follow the written directions.
- Display your written materials in an orderly yet accessible fashion in the waiting room. Make it clear that the materials are there to be taken.

3.4.2 Visual Materials and Models

- Keep bulletin boards attractive and uncluttered. Change the information often and keep it timely. A bulletin board is a good place for newspaper articles, flyers, letters, cartoons, etc. Display an attention getting headline, then tack up subsidiary items. Choose a location where the board is easily seen; at eye level and under sufficient light.
- Posters should be placed in a conspicuous spot and rotated through varied locations in the clinic (waiting room, exam room, etc.). A worn or yellowed poster looks terrible, as does one that has been in the same place for years.
- Have flip-charts available on a display table when not in use by an instructor. Flip-charts are good teaching devices for individual or group sessions; just be sure to elevate the chart so that it can be viewed by a group.
- When using a flannel or felt board, lean the board back slightly. Avoid excessive handling; it distracts the audience. Leave items on the board only as long as they are needed.
- Consider keeping a box containing available contraceptives in each exam room. The clinician can use the contraceptives as explanatory models, or they can be used to help a woman remember her previous pill brand, etc.
- Use air space in both waiting and exam rooms for mobiles. Choose a theme such as prenatal care or pap smear importance and use objects, photos and lettered signs to make a decorative mobile. (Expand all one dimensional pieces to four-sided objects, i.e., print a word on 4 sides of a cube. This keeps the message from getting lost when the mobile bobs around.)
- If models are on display in the waiting room, keep them accessible, yet out of the reach and mouths of small children. They can be dangerous.

- When using a blackboard, print in large readable letters. Use colored chalk for emphasis of important ideas and terms, and use a pointer.

3.4.3 Audio-Visuals

- Know the contents of the material. This is helpful in introducing the movie and in deciding whether to omit any sections. If only parts of a film are useful, these can be marked during the preview by inserting pieces of paper in the reel at the points where the film is to be started and stopped.
- Introduce the film. Tell the viewers what the film is about and suggest what they should look for.
- Use proper projection practices. Instruction sheets that come with the equipment and/or are printed on the projector case provide all necessary information. Always set up in advance and test the equipment. Keep a spare projection bulb on hand and know how to change it.
- Discuss the film. Ask and encourage questions from the audience about pertinent sections of the film. This provides a chance to correct misconceptions and explain vague or missed points.
- Re-show all or part of the film to give the audience a chance to grasp more fully the concepts presented and to pick up important details that may have been missed.
- Combine the film showing with other media. Bulletin boards and posters can be used to announce the program. A chalkboard, flannel board or flip-chart is helpful for listing important points when introducing a film and reviewing it after a showing. Mimeographed handouts or pamphlets distributed following the show remind the audience of what they saw.

3.4.4 Multi-Media Exhibits

- Display free samples. Anything that is free attracts attention. Try manufacturer's local outlets for free soap, toothpaste, hand lotion, or other sample products.
- Making parts of an exhibit "touchable" adds another attention-getting dimension to the presentation.
- Select a suitable, open location.
- Use an exhibit as an attention attractor at school, group or community presentations, bazaars or fairs.
- Exhibits can remain on display in the clinic when not in outside use. Even if the exhibit's theme is a permanant fixture, update and replace the subsidiary information periodically.

3.5 A Model: How to Develop Content for Contraceptive Education Materials

Developing client education materials on contraceptive methods can be an overwhelming task. Media people tell us that information which is brief and simply stated is the type most frequently remembered. However, given the amount of information available about each contraceptive method, it is not only difficult to limit the *number* of facts, but even more problematic to decide *which* facts to present. Also, it is vital that information be presented in an honest, consistent and clear fashion throughout all contraceptive materials. This information should be reinforced by the staff; the client should not be confused by conflicting or contradictory information.

Developing such materials, then, obviously requires staff and client input and cooperation. The following process is suggested as one approach:

Following are listed some facts about each contraceptive method that were compiled from various materials currently in use and from family planning clinicians and researchers. These facts are not necessarily all inclusive—you may wish to add others you consider important. Also, they are not necessarily worded in the manner that you may wish to present to your clients; "uterus," for instance, is referred to as "womb." We have endeavored to keep the sentences short and the ideas clear, but you may wish to modify the text.

Review each list and select the facts that you think every person using the method should know; label these as **Priority I** facts. These facts should be included in all client education materials on that particular method and should be presented in all available sources of information, e.g., pamphlets, classes, posters, interviews, counseling sessions and physician contact.

Going through the list, assign priority to the other facts, indicating *how often* and *when* these facts should be presented to clients. The higher the priority, the more often they should be presented. **Priority II** facts, for instance, might be presented in pamphlets, classes and posters, while **Priority III** facts would be presented only in classes and posters. This process should continue until the least important facts are conveyed to the client only through pamphlets.

Involving the staff in this process will enable them to become better informed and able to provide consistent information to the clients. For instance, before writing a pamphlet about the pill, meet with all the staff, including the medical staff. Go through all the facts the group knows about the pill—the way it works, beneficial and harmful side-effects, contraindications, costs, source, etc. List the facts as they are mentioned and then *as a group* decide the priority of facts you believe your patients should learn about the pill. This meeting can be conducted during a regular staff meeting or during an in-service training session.

(In order to involve your clinicians the meeting may have to take place during a time other than clinic hours; some clinics have found breakfast meetings a good time for getting full representation.)

Another approach might be to distribute the lists to staff members. Have them indicate which facts they consider important for client education, then compile the results and hold a meeting to finalize the list. During this meeting you can determine when and where in your clinic operation the various priorities of facts should be presented to the clients.

The effectiveness of family planning client education will be greatly increased if clients encounter a staff of well-trained health educators including counselors, aides, pharmacists and clinicians, all of whom present the clients with essential and consistent information about contraceptive methods. A first step toward developing a good client education program is to make certain that written material meets these standards and that your entire staff is prepared to present information as carefully as any pamphlet or brochure. Involving the staff in the development of your materials will be an educational experience for them and will benefit the clients by standardizing the information they receive from the staff members. By following the priority system, you may also eliminate overburdening a client with relatively unimportant information and avoid the risk of having important items lost in the maze of facts.

Most importantly, materials must be evaluated by clients before being finalized. Otherwise, information is developed totally from the perspective of the provider and may not respond to the needs and desires of clients. To assess the needs of your clients, you might develop a list of questions about contraceptive methods and distribute it to clients in the waiting room. Beside each question, ask them to check whether they are "very interested" in knowing the answer, "somewhat interested," "not interested," or "already know the answer." Clients should also evaluate the terminology used to ensure that it is consistent with common usage and understanding. This can serve to modify the staff's priority lists: Not only can clients tell you what they want to know, but you can avoid wasting time and money on redundant materials.

The Pill

- ☐ If taken correctly, pills are more effective than any other method of birth control except sterilization. However, if a woman forgets to take her pills, or takes them incorrectly, she can get pregnant.
- ☐ Of 100 women who take the pill for one year, between 0-5 of them may get pregnant. But, if all 100 of those women took the pill exactly right and never forgot, there would probably not be any pregnancies.
- ☐ Of 100 women who take (low progestin) "mini-pills" for a year, about 5-10 of them may get pregnant.
- ☐ In the U.S.A., a prescription is needed to obtain pills.
- ☐ A woman can get pills prescribed through a private doctor, a family planning clinic, a health department, a health insurance co-op, or a comprehensive health center.
- ☐ A pelvic examination is needed before a woman can obtain her first prescription for pills.
- ☐ A woman taking the pill should have a pap test every year in order to get a new prescription.
- ☐ The pill is fairly convenient, reliable and not messy.
- ☐ The pill is separated from the sex act.
- ☐ There are many hormones (chemicals in the blood) in a person's body that send signals to the body's organs and keep things running smoothly. The most common types of pills are made up of a combination of artificial hormones that are very much like the natural hormones in a woman's body, only they send different signals.
- ☐ The hormones in birth control pills send a signal to a woman's body that keeps her body from producing an egg. When there is no egg for the man's sperm to fertilize, a woman cannot get pregnant.
- ☐ The hormones in pills also change the mucus around the mouth of a woman's womb and also change the lining of her womb. This makes it harder for sperm to get past the mouth of the womb or for a fertilized egg to attach itself to begin growing on the wall of the womb.
- ☐ During the first two to three weeks on the pill, some clinicians recommend that another form of birth control, like foam or condoms, be used. This gives the pills a chance to "start working."

- [ ] The usual way to take pills is to take one pill a day for 20 or 21 days, depending on the number in the package. To begin the first package of pills, a woman waits for the 5th day of her menstrual period to take the first pill. She then takes one pill a day until the package is empty. Her menstrual period will then begin in a few days. Then, one week from the day that she finished the last package—regardless of whether she is still menstruating or not—she begins the next package of pills. This is how the cycle continues: 3 weeks on the pill, then 1 week off.

- [ ] If a woman takes birth control pills correctly, she is protected from pregnancy *all* the time, including the one week a month that she is "off" the pills.

- [ ] When a woman is taking the type of pills called "sequential" pills, the first 14 pills in the package contain only the hormone estrogen, and the next 7 pills are a combination of the 2 hormones estrogen and progesterone. Women who take this type of pill must be careful to take the right pill on the right day.

- [ ] Some brands of pills have 28 pills to the package, but the last 7 pills usually don't have any birth control hormones in them. The last 7 pills may be iron pills, which are good for a woman, but are not for birth control.

- [ ] The (low progestin) "mini-pills" have birth control hormones in every pill in the package. A woman takes a "mini-pill" *every* day, even during her period.

- [ ] Birth control pills keep a woman from getting pregnant only when she takes them correctly. Pills taken just once in awhile or carelessly will not be effective birth control. A pill taken on Tuesday night, for instance, does not specifically protect a woman from getting pregnant from sexual relations on Tuesday night. Instead, each pill adds to the "chain" of protection that taking a daily pill builds up. It is this "chain," *not* a single pill, that prevents pregnancy.

- [ ] A woman should try to make taking her pill a part of her daily routine so that she will not forget. A woman may find it easier to remember the pill if she associates taking it with something she does every day at a certain time—like brushing her teeth, watching the news, or taking out the garbage.

- [ ] If a pill is forgotten, a woman should take the forgotten pill immediately. Or, if she starts to take Wednesday's pill, for example, and then notices that she has forgotten to take Tuesday's, she should take the 2 pills together. If more than one pill is forgotten—for example, if both Tuesday's and Wednesday's pills are forgotten—a woman should take 2

pills on both Thursday and Friday and continue with the cycle. However, during the rest of the cycle, she should use an *additional* method of birth control (such as foam or condoms)—just in case the "chain" of protection built up by the pills has been broken.

☐ If a woman misses a period while on the pill, she may wish to call her clinic. However, she should also start taking the next month's supply of pills on schedule. If she misses a second period, she should go to the clinic for a pregnancy test.

☐ Once a woman stops taking the pill, pregnancy can occur. Only occasionally will a woman have trouble getting pregnant after she stops taking the pill.

☐ There may be a delay in menstruation after a woman stops taking the pill.

☐ Some women should not take pills for health reasons. Pills may not be a safe method of birth control for women who have a history of breast cancer, blood clots, migraine headaches, liver disease, etc. Before giving pills to a woman, a clinician will take a complete medical history to check for such problems.

☐ Some women's bodies may have a difficult time getting used to the new hormones in the pill. Some women may find that they gain weight, or have breast enlargement and tenderness, nausea, bleeding or spotting between periods, and nervousness or depression. If these conditions continue for several months, or if they are severe, the family planning clinician may take the woman off pills or prescribe a different type of pill.

☐ In some women, starting pills may cause a weight gain due to water retained in the body. This is usually not more than 5-10 pounds.

☐ When a woman is taking birth control pills, taking an antibiotic drug (such as penicillin) may cause some problems with infections in the vagina. If a doctor prescribes another drug for a woman who is on the pill, she should be sure to mention that she is taking birth control pills.

☐ Pills make most women's menstrual periods more regular.

☐ Pills may make some women's menstrual flow lighter, and occasionally some women miss a period entirely while on pills.

- [ ] Pills may decrease some women's menstrual cramps, though occasionally cramping is increased.
- [ ] Pills may clear up a woman's acne, though occasionally taking pills can make acne worse.
- [ ] Taking the pill usually doesn't change a woman's sexual nature or affect sex relations. Some women have found that taking the pill improves sex relations and enjoyment because they no longer have to worry about getting pregnant.
- [ ] A woman who develops headaches, blurred vision, leg pain or chest pain while on the pill should return to her clinic immediately.
- [ ] It is dangerous for a woman to take anyone else's birth control pills. Different women need different types of pills, and a woman must be examined by a family planning clinician before pills are prescribed.
- [ ] There have been many rumors about the pill causing cancer. Although studies have not found that there is a connection, women on the pill should have a yearly check for cancer (a pap smear) in order to get a new pill prescription.
- [ ] Most pills come in one-month packages.
- [ ] Pills cost from about $1.50 - $3.00 for a month's supply from a drugstore. Pills are available at low cost or no cost at many family planning clinics.
- [ ] Like any other medicines, birth control pills should be kept out of the reach of small children. However, if a child should happen to swallow some pills, there is no cause for alarm. Even a whole package of pills taken at once will not cause any damage.

The IUD

- [ ] Out of every 100 women using IUDs for a year, between 2-5 may become pregnant.
- [ ] IUDs are small plastic shapes with thin nylon threads attached to the bottom.
- [ ] The IUD lies in a woman's womb. The thin nylon strings hang into her vagina and can be checked by the woman.
- [ ] There are different shapes and sizes of IUDs. Some of them are "the loop," "the spiral," and "the shield." Some people call an IUD "the device," or "the coil." (NOTE: In literature, it is a good idea to picture a few types.)
- [ ] The proper type of IUD is inserted into a woman's womb by a family planning clinician. While in place the IUD prevents pregnancy.
- [ ] No one is really sure exactly how the IUD works to prevent pregnancy. It is thought that the IUD keeps the fertilized egg from attaching to the wall of the womb. This prevents the pregnancy from starting.
- [ ] Most IUDs can be left in place for long periods of time. However, the new IUDs that have copper in them must be replaced every few years, and the new IUDs with hormones should be replaced every year or so.
- [ ] A woman may have an IUD inserted at a doctor's office or a family planning clinic.
- [ ] When properly inserted the IUD is not usually felt by either sex partner. If either partner can feel the hard plastic part of the IUD, it means that the device is coming out and the woman should go to her clinic immediately.
- [ ] An IUD is a good method for someone who doesn't want to bother with taking daily pills or doesn't want to have to think about using a method every time she has sex relations. An IUD is also a good method for those who want convenience. It is not messy, and a woman doesn't have to think about it each day or each time she has intercourse.
- [ ] The IUD is always there when needed.
- [ ] Most women get used to an IUD quite easily. Some—particularly women who haven't had children—may have some cramps and heavier menstrual bleeding.

- [ ] Possible side effects of having an IUD may be some discharge and odor, which may be signs of an infection. If the discharge becomes unusually heavy or the odor becomes very foul, it may be a sign of infection.

- [ ] The most serious problem with an IUD is a possible infection in the womb or tubes. A woman needs to know the signs: If she has a sudden onset of severe pelvic pain or tenderness, unusual bleeding, fever, foul discharge, or if sex relations become painful, she should call her clinic immediately.

- [ ] In case of severe pain or bleeding, the family planning clinician will remove the IUD.

- [ ] Since the first month of having an IUD is the time it is most likely to fail, a woman might choose to use an additional method of birth control, such as foam or condoms, during this time. This gives the IUD a chance to "start working."

- [ ] Many women with IUDs will choose to use an additional method of birth control during the middle of each cycle (when pregnancy is most likely to occur). This provides double protection against pregnancy.

- [ ] Heavier menstrual periods are to be expected for the first few months after an IUD is inserted. Some women continue to bleed more heavily even after the first few months.

- [ ] An IUD doesn't usually affect sex relations except by relieving tension about getting pregnant. Occasionally, the man can feel the strings.

- [ ] Having an IUD doesn't change a woman's sexual nature or enjoyment.

- [ ] There is a very small chance that an IUD may slip out unnoticed. This is why a woman should be sure to check for the IUD's strings after each period. The longer the woman has the IUD, the more rare is the chance of this happening.

- [ ] A woman should check for the IUD after each menstrual period by feeling for the nylon strings. If they are there, the IUD is in place.

- [ ] In a very few cases, an IUD has been known to go through the wall of the womb (perforate the uterus) either during the insertion by the clinician or afterwards. This is very rare, but it can be dangerous and should have immediate medical attention. If a woman has severe pelvic pain and suspects that this has happened, she should go to her clinic at once.

- [ ] Having an IUD inserted can be painful for some women, especially those who haven't had children. Some women may want to have some medication to ease pain before they have an IUD inserted.

- [ ] Many clinicians recommend that a woman have her IUD inserted when she is having her period. Because this is a time of the month when the mouth of the womb is most "relaxed," it is probably the least painful time for a woman to have an IUD inserted. Also, this assures that the woman is not pregnant.

- [ ] If a woman wants to have a child, she has the IUD removed by a family planning clinician.

- [ ] The total cost of an IUD is usually about $20 - $35 and includes the appointment checkup, the insertion of the IUD, and a follow-up visit. IUDs are available at low cost or no cost at many family planning clinics.

The Diaphragm and Contraceptive Cream/Jelly

- [ ] For every 100 women who use the diaphragm and contraceptive cream or jelly correctly for one year, about 3-5 of them may become pregnant. However, if those 100 women were to use the method incorrectly or only some of the time, there is a chance that about 20 of them might become pregnant.

- [ ] For the diaphragm and contracepive cream or jelly to be a really effective method of birth control, it is important that it is used correctly *every time* a woman has sexual relations.

- [ ] The diaphragm is a soft, dome-shaped device made of rubber stretched over a flexible ring. When a woman inserts it into her vagina properly, it fits snugly over the mouth of the womb and works with the contraceptive cream or jelly to block the man's sperm from reaching the egg. (NOTE: An illustration is helpful.)

- [ ] The diaphragm *must* be used with contraceptive cream or jelly. About one teaspoonful is put inside the curve of the diaphragm, and one teaspoonful around its stiffened edges.

- [ ] The diaphragm and the foam or jelly work *together* to prevent pregnancy by keeping a man's sperm from getting up into the womb and tubes to reach the woman's egg.

- [ ] The cream or jelly that is used with the diaphragm kills sperm. The diaphragm itself keeps them from entering the womb.

- [ ] There is no difference in the effectiveness of contraceptive cream and jelly. They work equally well to kill sperm. The only difference is that jelly provides more lubrication in the vagina.

- [ ] The diaphragm must be used regularly and properly, with contraceptive cream or jelly, in order to be effective.

- [ ] Diaphragms must be fitted by a medically qualified person who will then show a woman how to insert the diaphragm herself.

- [ ] A family planning clinician will fit a woman for the proper size diaphragm and give her a prescription which can be filled at a drugstore. Some clinics have diaphragms available. A woman can get the contraceptive cream or jelly either at the drugstore or her clinic.

- [ ] Just as women wear different hat, ring, or dress sizes, women wear different diaphragm sizes. In order for the diaphragm to work properly, it must be the right size and fit.

- [ ] A diaphragm must be refitted after childbirth, miscarriage, abortion, surgery, and a gain or loss of weight of ten pounds or more. Also, it should be checked every two years to be sure that the size and fit are still correct.

- [ ] If properly fitted and inserted, a diaphragm is usually not felt by the man or woman during intercourse. If it is felt by either partner, it should be checked for fit and placement.

- [ ] A woman may insert the diaphragm (with the jelly or cream) as long as six to eight hours before sexual relations. However, if the diaphragm has been in for more than 2 hours before intercourse, a woman should insert more cream or jelly into her vagina before having sexual relations. She should *not* remove the diaphragm to do this.

- [ ] If a couple desires intercourse more than once with the diaphragm in place, then additional contraceptive cream or jelly must be inserted into the woman's vagina. The diaphragm should *not* be removed; the additional cream or jelly should be inserted directly into the vagina.

- [ ] The diaphragm must be left in for at least six hours after intercourse. Otherwise, sperm still alive in the vagina may be able to get up past the mouth of the womb to fertilize the woman's egg and cause pregnancy.

- [ ] After the diaphragm is removed it should be washed, dried, and powdered with corn starch. It will last longer and be more effective if it is cared for properly.

- [ ] Six to eight hours after intercourse, a woman may remove the diaphragm and douche to remove the extra jelly or cream in her vagina if she wishes to do so. But a douche is not necessary and under any circumstances must not be used for at least six hours after sex relations.

- [ ] Clinicians think that using a diaphragm probably provides some protection against venereal disease (VD).

- [ ] Using a diaphragm effectively takes planning and some equipment every time.

- [ ] Some women may find using a diaphragm inconvenient or messy.

- [ ] An advantage of the diaphragm is that it can hold back about 24 hours of menstrual blood and can make for tidier lovemaking during a woman's period.

- [ ] Some women do not like to insert and remove the diaphragm, which may affect their attitude toward using it regularly during sexual relations.

- [ ] At a drugstore, diaphragms range in cost from $3.00 to $5.50 (this does not include the clinician's fee for fitting it). Diaphragms are available at low cost or no cost at many family planning clinics. The contraceptive jelly or cream may come with the diaphragm or may be bought separately at either a drugstore or a clinic. No prescription is necessary to buy the cream or jelly.

The Condom

- [ ] If their partners used the condom regularly and carefully, about 4-6 out of every 100 women might get pregnant. Actually, since people make mistakes or are careless, about 15-20 pregnancies might occur for every 100 women whose partners use the condom.

- [ ] The condom is a thin disposable sheath (like the finger of a glove) made of rubber, gut or plastic. The man wears it over his penis during intercourse.

- [ ] Condoms are also called "rubbers" or "sheaths."

- [ ] Condoms are the most popular contraceptive in the world today because they are easy to use, cheap, and effective if used properly.

- [ ] The condom catches the man's semen when he comes and keeps his sperm from reaching the woman's egg. This prevents pregnancy.

- [ ] The condom should be unrolled over the penis after the man gets hard, but before his penis enters the woman's vagina and well before he comes.

- [ ] It is important that the condom be placed on the man's penis early. Long before the man actually comes, a few drops of lubricating fluid come from the end of the penis. This fluid may contain sperm which could lead to pregnancy.

- [ ] The man should hold on to the base of the condom as he withdraws his penis from the woman's body. This will keep the condom from slipping off and spilling the semen into the woman's vagina.

- [ ] After the man comes, he should withdraw his penis and remove the condom away from the vagina to keep any sperm from being spilled into the vagina.

- [ ] Condoms are an especially good method of birth control for people who don't have sex relations very regularly.

- [ ] A condom is a very effective method of birth control when used together with foam. Using these two methods together provides 95% protection against pregnancy.

- [ ] Not all condoms have nipple ends to catch the semen. If the condom does not have a nipple end, a man must be careful to leave room at the tip for the semen.

- [ ] Not all condoms are lubricated. Non-lubricated condoms are somewhat more likely to tear than the lubricated type.
- [ ] Some men say that using a condom interferes with full sexual pleasure.
- [ ] Loveplay before actual sexual relations may be interrupted by having to put on a condom. However, putting on a condom can be made part of the loveplay by having the woman place it on the penis.
- [ ] If a couple is comfortable enough with each other to make the placing of the condom on the penis a part of lovemaking, it should have no effect on sex relations.
- [ ] A condom may sometimes break or tear, especially if it is not put on correctly. If this happens during intercourse, contraceptive foam or jelly should be inserted into the vagina immediately. If this happens midway between a woman's periods (her most fertile time), she should call her clinic as soon as possible. A family planning clinician can give her some medication or insert an IUD to protect her from possible pregnancy.
- [ ] Vaseline should never be used to lubricate unlubricated condoms. Vaseline can eat away at the rubber and cause little holes that will allow sperm to get through.
- [ ] A condom should not be used more than once.
- [ ] A condom should not be removed from its package until just before it is to be used.
- [ ] Condoms are an excellent way of preventing the spread of venereal disease (VD). By reducing the amount of contact between a man's and woman's sex organs, the chance of passing VD is lessened.
- [ ] Condoms are a good backup method for women who are using other methods of birth control. Especially at mid-cycle (the most fertile time), a woman using foam, an IUD, or a diaphragm may also wish to use condoms for double protection against pregnancy.
- [ ] No prescription is needed to get condoms.
- [ ] Condoms cost 25-35¢ or more each at drugstores. They are often available at low cost or no cost at many family planning clinics.

Contraceptive Foam

- [ ] If 100 women used foam correctly for one year, about 5 of them might get pregnant. However, because of mistakes or being careless, about 30 out of every 100 women using foam may get pregnant.

- [ ] There are a number of mistakes that can be made when using foam as the only method of birth control, and a woman who doesn't want to become pregnant must be careful to avoid them. For instance, a woman's chance of getting pregnant goes up if she doesn't use enough foam, forgets (even once in awhile) to use the foam, or douches within 6-8 hours after using foam and having sexual relations.

- [ ] Foam is a chemical solution in a small aerosol container. The chemical solution is spermicidal—that is, it kills sperm before they can reach the woman's egg to cause pregnancy.

- [ ] To use foam correctly a woman shakes the bottle thoroughly, about 20 times, then fills the applicator with foam. Lying down, she inserts the applicator into the vagina and pushes the plunger of the applicator to release the foam over the mouth of the womb.

- [ ] Some brands of foam are now improved so that the applicators can be filled (and capped) up to several days before use. This way, a woman can simply insert the applicator instead of shaking up the bottle and filling the applicator at the same time. Some women find that this is less of an interruption of loveplay and makes foam easier to use.

- [ ] It is important that foam be inserted deep into the vagina with the plastic applicator. The foam should be released over the mouth of the womb to become a chemical barrier and prevent sperm from passing upwards to meet the woman's egg.

- [ ] Foam must be inserted into the vagina no more than half an hour before each sex act. The closer to the sex act that foam is inserted, the more effective it is.

- [ ] Inserting two applicators of foam instead of just one is better protection against pregnancy. A woman should use an additional applicator of foam each time intercourse is repeated.

- [ ] If a woman has had two or more children, she should use 3 applicators of foam every time she has sexual relations.

- [ ] Some people do not like having to use a contraceptive before each sex act. For these people, foam may not be the best method.
- [ ] Some people may find foam messy or inconvenient.
- [ ] Foam can be made a part of loveplay by having the man insert it into the vagina.
- [ ] In some rare cases, foam can cause irritation of the vagina or the penis.
- [ ] A woman should not douche for six to eight hours after using foam. Douching may remove the foam's protection and allow sperm still in the vagina to reach a woman's egg and cause pregnancy.
- [ ] Women should be careful not to confuse "feminine hygiene" sprays, tablets and foams with contraceptive foam. "Feminine hygiene" products are *not* for birth control and will not help at all in preventing pregnancy. Contraceptive foam is labeled as being for birth control.
- [ ] No prescription is needed to obtain foam.
- [ ] With most brands of foam, it is almost impossible to tell when the container is about to run out. For this reason, it is best to always have an extra container of foam available.
- [ ] When a condom and foam are used together, they make one of the best contraceptive methods —about 95% effective. Neither one requires a prescription.
- [ ] Foam is also a good backup method, especially midway between periods (a woman's most fertile time). A woman using a diaphragm or an IUD may wish to use foam for double protection against pregnancy.
- [ ] The cost of foam ranges from $2.25 to $3.95 for a whole kit at a drugstore. This kit includes enough foam for about a month, plus an applicator, a carrying case and instructions. The applicator and carrying case can be re-used, and a single container of foam costs less than the entire kit. Foam is available at low cost or no cost at many family planning clinics.

Voluntary Sterilization

- [ ] Sterilization is virtually 100% effective.
- [ ] Sterilization is a permanent method of birth control. Many people who are sure that they don't want any children or that they have had all the children they want choose sterilization.
- [ ] There are very few side effects to any of the sterilization operations.
- [ ] Most patients report satisfaction with sterilization operations. Many feel that removing the fear of pregnancy improves sexual relations.
- [ ] Neither female or male sex hormones are changed *at all* by a sterilization operation.
- [ ] The female sterilization operation is called a *tubal ligation;* there is also a new type of tubal ligation operation called *laparoscopy*. The male sterilizaton operation is called *vasectomy*.
- [ ] There is *some* risk in all surgery, but modern techniques of vasectomy, tubal ligation and laparoscopy are very safe.
- [ ] During the tubal ligation operation, a woman's fallopian tubes are closed off and tied. This prevents her eggs from being reached and fertilized by a man's sperm. The eggs are harmlessly reabsorbed into the woman's body.
- [ ] The tubal ligation operation usually requires a hospital stay of several days and is considered a fairly major operation.
- [ ] A laparoscopy is a new and easy sterilization operation for a woman. It is a new type of tubal ligation. A small incision is made in the abdomen and a special electrical instrument is used to close off the tubes. This prevents a woman's eggs from being reached and fertilized by a man's sperm. The eggs are harmlessly reabsorbed into the woman's body.
- [ ] The new laparoscopy operation usually allows a woman to go home the same day or the day after the operation.
- [ ] A tubal ligation or laparoscopy does not decrease a woman's sexual enjoyment, drive or change feminine nature. In fact, not having to worry about pregnancy may increase a woman's sexual pleasure.

- [ ] A woman continues to have periods after a sterilization operation. She still needs to have yearly checkups and pap tests.

- [ ] Vasectomy is the sterilization operation for a man. The tubes are tied shut which bring sperm to join the fluid which is ejaculated when a man comes. Since sperm are a very small part of the total fluid, there is no noticeable difference in the amount of a man's ejaculation. Only the sperm are blocked from joining the rest of the fluid, which prevents a man from getting a woman pregnant.

- [ ] The sperm that cannot join the seminal fluid after a vasectomy are usually harmlessly reabsorbed into the man's body.

- [ ] A vasectomy does not decrease sex drive, manliness or amount of orgasms. Many men find that since they no longer fear pregnancy, their sex drive increases.

- [ ] Vasectomy is clean, quick and painless, with only rare side effects.

- [ ] Because some sperm remain in the sex organs, a man is still fertile for a month or longer after a vasectomy. The clinician will test a man to determine when there are no more sperm in the semen. In the meantime, the man and woman should continue to use their regular contraceptive method.

- [ ] A vasectomy can be done in a doctor's office or family planning clinic and usually does not require an overnight stay in a hospital.

- [ ] Sterilization is the most effective method of birth control. It should be considered permanent since there is no guarantee that the operation can be reversed.

- [ ] The cost of vasectomy usually ranges between $50-$150, depending on whether it is done by a private physician or in a family planning clinic.

- [ ] The cost of a tubal ligation right after childbirth is approximately $125-$250. At other times, there is the additional cost of a hospital stay. A laparoscopy operation may cost somewhat less since it may not require a hospital stay.

Rhythm

- ☐ Out of every 100 women using rhythm for a year, as many as 40 may become pregnant.
- ☐ To use rhythm most effectively a woman should have a regular menstrual cycle. She needs to record her menstrual periods and keep a chart of her early morning temperature for several months before beginning to use the method. A woman should consult her doctor or family planning clinic for help in charting her fertile period.
- ☐ A woman should consult her family planning clinic for help in charting and determining her fertile period.
- ☐ The idea behind the rhythm method is that a woman charts her menstrual cycle, figures out when her body is producing an egg (when she is fertile and most likely to get pregnant), and avoids having sexual relations during that time. She must not have intercourse just before, during, or after her body releases an egg—which is usually the middle 8-12 days in between menstrual periods.
- ☐ Using the calendar method, a woman should keep track of her menstrual cycle for at least 6 months before beginning to rely on the rhythm method for birth control.
- ☐ When counting days in the menstrual cycle, the first day of bleeding is always called "DAY 1." A woman counts from DAY 1 of her cycle until she begins to bleed again; then that day is called DAY 1 of the *next* cycle.
- ☐ From her record of menstrual cycles, a woman notes her shortest and longest cycles. She counts the number of days in the shortest cycle, and subtracts 18 days from that number. She counts the number of days in the longest cycle and subtracts 11 days from that number. The answers to these subtractions give a woman the range of her fertile (unsafe) period. For example: if a woman's shortest cycle is 22 days and her longest cycle is 30 days, her fertile (unsafe) period is between days 3 and 19 of her menstrual cycle.

☐ A woman may use the following chart to figure out her fertile (unsafe) period. (NOTE: This chart is based on the above instructions for calculation.)

Count the First Day of Bleeding as Day 1

If Your Shortest Period Has Been	Your First Fertile (Unsafe) Day Is	If Your Longest Period Has Been	Your Last Fertile (Unsafe) Day Is
21 days	3rd day	21 days	10th day
22 "	4th "	22 "	11th "
23 "	5th "	23 "	12th "
24 "	6th "	24 "	13th "
25 "	7th "	25 "	14th "
26 "	8th "	26 "	15th "
27 "	9th "	27 "	16th "
28 "	10th "	28 "	17th "
29 "	11th "	29 "	18th "
30 "	12th "	30 "	19th "
31 "	13th "	31 "	20th "
32 "	14th "	32 "	21st "
33 "	15th "	33 "	22nd "
34 "	16th "	34 "	23rd "
35 "	17th "	35 "	24th "

☐ Some women find that they can tell when they're ovulating (producing an egg) by a twinge of pain in the abdomen.

☐ Charting the menstrual cycle by the calendar method alone is not very reliable. A woman should also chart her basal body temperature (BBT) and keep track of changes in her cervical mucus (the mucus on the mouth of the womb).

☐ To chart her basal body temperature (BBT), a woman takes her temperature *every* morning with a special BBT thermometer that notes very small temperature changes. Because body temperature may change with movement, a woman should take her temperature before getting out of bed or beginning any activity. She should keep a daily record of each BBT.

☐ Whatever a woman's normal temperature, there are changes in her BBT that indicate when ovulation happens (when her body is producing an egg and when she is most fertile). A woman's BBT will begin to drop just before she ovulates, and will be at its lowest at the time of ovulation. Then, about 24 hours after ovulation, there is a rise in BBT.

☐ The woman's fertile period begins when her BBT begins to drop and ends about 24-28 hours after the BBT rise.

☐ A woman's BBT may be affected by such factors as illness, nervous tension, or even a restless night's sleep. By keeping a regular record of her BBT, a woman may be able to check back to see if her BBT change is caused by ovulation or by one of these factors.

☐ A woman's total unsafe period is actually *longer* than the fertile period that she calculates by the BBT method. There are two main reasons for this: Both the woman's egg and the man's sperm can live in the womb and tubes for as long as several days. Therefore, if a woman has sex relations and then ovulates within the next day or so, there may still be sperm alive in the womb or tubes that can meet the egg and begin pregnancy. On the other hand, if a woman ovulates and then has sex a day or so later, her egg may still be alive in the tubes where sperm may meet it and cause pregnancy.

☐ The mucus that is always present on the mouth of the womb (the cervix) changes during the different stages of the menstrual cycle. Even a woman with irregular menstrual cycles can figure out her fertile period by checking the changes in her cervical mucus.

☐ The body produces more cervical mucus at the beginning of the fertile (unsafe) period, and a woman may notice a small amount of discharge of the mucus. A woman can check the amount and type of cervical mucus either on toilet paper or by reaching up into the vagina to feel the cervix (mouth of the womb).

☐ At the beginning of the fertile (unsafe) period, the cervical mucus changes to become rather "shiny," sticky, slippery and clear. This change in the cervical mucus can tell a woman when her fertile period is beginning.

☐ The change in cervical mucus is the best way for a woman to tell that her fertile period is beginning, but it will not tell her when the fertile period is ending. On the other hand, the BBT method makes it easy to tell when the fertile period is ending, but not so easy to tell when it is beginning. Therefore, the best way to figure out the fertile period is to check the cervical mucus for the beginning, and check the BBT for the ending: When the amount and type of the cervical mucus begins to change, the fertile period is beginning. When a woman's BBT rises after ovulation and stays up for ~~about 3 days~~, then her fertile period is ended.

☐ It is very difficult for a woman with a very irregular menstrual cycle to use rhythm effectively. Her chances of getting pregnant are quite high.

☐ Using rhythm effectively means that a couple cannot have sexual relations for quite a long period of time each month. This takes a lot of planning, self-control and cooperation. Many couples find it hard to refrain from sexual relations for the length of time needed to be safe from pregnancy.

☐ Even the "safe time" isn't always safe—sometimes a woman's body will make an egg "off schedule" and the woman will get pregnant anyway.

- [ ] For people using the rhythm method, the safest time of the cycle for sex relations is during the woman's menstrual period. Even then, it is not 100% safe. A woman's body may produce an egg even during her period.

- [ ] Certain factors in a woman's life may cause an egg to be produced "off schedule"; e.g., VD, nervous tension, illness, certain drugs.

- [ ] There is little, if any, religious objection to this method.

- [ ] Women who are trying to become pregnant should know the facts of the rhythm method so that they can plan to have sexual relations during the fertile period.

- [ ] A basal body temperature kit costs about $3-5 at a drugstore. Menstrual cycle charts for recording BBT, cervical mucus changes and dates of menstruation are sometimes available at family planning clinics.

3.6 Questions and Answers About Family Planning Education Materials

- *How Do You Select and Develop Good Educational Materials?*

It is vital that you examine the material you propose to use very carefully before making use of it in the clinic. Know what the material is for and if it meets the purpose. (Written information about a film or booklet, for instance, can sometimes be deceiving.) Have a group of your clients preview and evaluate the material. Keep the following in mind when choosing materials:

- *Authenticity:* Facts should be presented in an accurate, up-dated and impartial fashion.
- *Appropriateness:* Are the vocabulary and concepts presented appropriate for the intended audience? Are narration, title, etc. related to the subject? Is it suitable for use with a group or with individuals? Do you have the right equipment, place or personnel to make use of the material?
- *Scope:* The subject should be fully covered with no gaps in information.
- *Interest:* Is the material related to the experiences of the intended audience? Will it appeal to their senses and imagination? Will it satisfy their curiosity?
- *Organization:* The material should be logically developed; the information should be pertinent.

- *How Can Printed Materials Be Developed Within A Very Limited Budget?*

To cut down on printing costs, shop around for a cooperative printer. Also, keep in mind that the more you do yourself (choosing print style, setting up layout, etc.) the less you will have to pay the printer to do. Allow ample time to have several people proof the material before it goes to press – this will avoid costly reruns or errors. Deal in volume printing, but take a small order on new material first. Then, when everything is correct, order a larger run. Also, ask the printer about discounts on left-over paper stock – this can be a big money saver.

You might consider "personalizing" a piece of already developed literature to make it fit your clinic. For instance, you could buy a well done pamphlet or booklet from another organization and have your clinic's floor plan, staff names, hours, location, etc. printed onto a blank space in the pamphlet. (Be sure to get permission from the organization to do this, and credit them for developing the material.)

- *How Can Someone With Little Artistic Talent Develop Good Visual Materials?*

Put a small illustration, object or letter under an opaque or overhead projector. Project it on a surface, then trace around the enlargement.

- *How Are Available Educational Materials Best Used and/or Displayed?*

Some possible ways are:

- Methods display: Put out contraceptive samples for inspection.
- Flip-chart: Have it available at all times, not just when it is being used by counselors.
- Models, brochures, pamphlets: Have such items available and accessible on a table.
- Posters: Have posters mounted on cardboard or framed. Rotate them through different locations throughout the office.
- Bulletin boards: Place complicated visuals where people can study them at their leisure—out of the line of traffic. Put simple, eye-catching items in well-traveled areas.

4.0 Bibliography of Family Planning Materials

4.1 Introduction

This bibliography lists materials relevant to family planning programs and professionals. The references vary in character and applicability: some are actual client education materials, while others speak to the questions and needs of those who work in clinical or program areas of family planning. The overall aim of this bibliography is to make available to you a list of materials which may have practical applications to your program.

In Section 4.2, materials are indexed, and in some cases cross-indexed, by subject matter. The article "Adolescents' Attitudes Toward Abortion," for example, will be found under both "Abortion" and "Teenagers." The subject headings for the materials listed in the following section are:

- Abortion
- Client Education
- Communications
- Contraception
- Feminist Movement
- Foreign Language Materials
- Men
- The Mentally Retarded
- Program Management and Evaluation
- Sex Education
- Staff Training
- Teenagers
- Venereal Disease
- Voluntary Sterilization

Information in each subject area is subdivided into:

- Books
- Booklets and Pamphlets
- Comic Books
- Films and Other Audio-Visual Materials
- Journal Articles
- Miscellaneous Materials (flip-charts, models, posters, etc.)

To assist you in locating the listed materials, an alphabetical *Publishers and Suppliers* Index (Section 4.3) follows the bibliography. Section 4.4, *Journals and Other Publications*, lists periodicals that emphasize or include articles relevant to clinical and program aspects of family planning. Costs and frequency of publication are noted.

This bibliography was researched and developed in 1973-1974. Listings were selected through a search of original materials and the following sources:

Katherine Dexter McCormick Library. *A Selected Bibliography*. New York, New York: Planned Parenthood-World Population.

Katherine Dexter McCormick Library. *A Small Library in Family Planning*. New York, New York: Planned Parenthood-World Population, 1972.

Film Library. Planned Parenthood-World Population, 810-7th Ave., New York, New York.

Family Planning Training Institute. *Educational Materials*. Baltimore, Maryland: Planned Parenthood Association of Maryland.

New York State Cooperative Extension and COSPA/NY. *An Introductory Bibliographical Guide on Sex Education and Human Sexuality*. Ithaca, New York: Cornell University, 1972.

Young, Marjorie A.C. "Review of Research and Studies on Health Education and Related Aspects of Family Planning (1967-1971): Behavioral and Cultural Factors." *Health Education Monographs*, #34, 1973.

"Review of Research and Studies on Health Education and Related Aspects of Family Planning: Program Planning and Evaluation." *Health Education Monographs*, #35, 1973.

4.2 Materials Listed by Subject Heading

Abortion

Books:

Callahan, D. *Abortion: Law, Choice and Morality*. New York: Macmillan Co., 1970.

Ebon, M., ed. *Everywoman's Guide to Abortion*. New York: Universe Books, 1971.

Lader, L. *Abortion*. Boston: Beacon Press, 1966.

Booklets and Pamphlets:

"Abortion." New York: Community Sex Information and Education Service, 1971.

"Abortion" and Spanish version, "Aborto." Brooklyn, New York: Family Planning Resources Center Publications.

"Abortion (English and Spanish)." London, England: International Planned Parenthood Federation.

"Abortion—Questions and Answers." New York: National Association for Repeal of Abortion Laws.

"A Guide to Contraception and Abortion." Durham, North Carolina: Martin L. Schwartz.

Comic Book:

"Abortion Eve." San Francisco: Multi Media Resource Center.

Films and Other Audio-Visual Materials:

Abortion Without Cervical Dilation. Covers counseling, suction aspiration technique and procedure, and follow-up counseling. For professional audiences only. 12 min., color, 16 mm. C.O.R.T. Motion Pictures, 1971.

Aspiration Abortion. Demonstrates suction technique and patient education for the procedure. 13 min., color, 16 mm. Berkeley Bio-Engineering, Inc., 1971.

Each Child Loved. Illegal abortion contrasted with legal, safe abortion; documentary style. 40 min., color, 16 mm. Planned Parenthood - World Population, 1970.

It Happens to Us. Women discuss abortion and its problems. 30 min., color, 16 mm. New Day Films, 1972.

Termination with Safety. Technique of vacuum aspiration. For professional audiences only. 27 min., color, 16 mm. The Lalor Foundation, 1972.

Women Who Have Had an Abortion. Discussion among women who have experienced abortion. 28 min., color 16 mm. Martha Stuart Communications, Inc., 1972.

Journal Articles:

Dauber, B., M. Zalar and P.J. Goldstein. "Abortion Counseling and Behavioral Change." *Family Planning Perspectives*, IV (April, 1972), 23-7.

Gabrielson, I., S. Goldsmith et al. "Adolescents' Attitudes Toward Abortion." *American Journal of Public Health*, Vol. 61, No. 4, 730.

Client Education

Books:

Harman, D. *Functional Education for Family Life Planning, II: Program Design.* New York: World Education, 1973.

Hubbard, C.W. *Family Planning Education: Parenthood and Social Disease Control.* St. Louis, Missouri: C.B. Mosby Co., 1973.

Booklets and Pamphlets:

Crow, M. and F. Guest, eds. "True to Life." Atlanta, Georgia: Emory University Family Planning Program, 1972.

Gray, M. and R. "How to Take the Worry Out of Being Close: An Egg and Sperm Handbook." Oakland, California, 1971.

"I May Save My Own Life." Atlanta, Georgia: Emory University Family Planning Program.

"The Pelvic Examination." Atlanta, Georgia: Emory University Family Planning Program.

"To Be a Mother; To Be a Father." New York: Planned Parenthood-World Population.

Films and Other Audio-Visuals:

Menstruation. Light and humorous. Combination of animation and acting explains the menstrual cycle and many of the attendant feelings about menstruation. 18 min., color, 16 mm. Phoenix Films, 1974.

Journal Articles:

Crow, M., B.R. Bradshaw and F. Guest. "True to Life: A Relevant Approach to Patient Education." *American Journal of Public Health*, LXII (October, 1972), 1328-30.

Communications

Books:

Bogue, D.J. and V.S. Heiskanen. *How to Improve Written Communication for Birth Control*. Chicago, Illinois: Community and Family Study Center, University of Chicago Press, 1963.

Bogue, D.J., ed. *Mass Communication and Motivation for Birth Control*. Chicago, Illinois: Community and Family Study Center, University of Chicago Press, 1967.

Brown, J.W. et al. *A-V Instruction: Media and Methods*. New York: McGraw-Hill, 1968.

Erikson, C.W. *Administering Instructional Media Programs*. New York: Macmillan, 1968.

Kemp, J.E. *Planning and Producing Audiovisual Materials*. Scranton, Pa.: Chandler Publishing Co., 1968.

Kline, F.G. and P.J. Tichenor, eds. *Current Perspectives in Mass Communication Research*. Beverly Hills, California: Sage Publications, 1972.

*Morlan, J.E. *Preparation of Inexpensive Teaching Materials*. 2nd edition. San Francisco, California: Chandler Publishing Co., 1973.

Nieme, J.A., ed. *Mass Media and Adult Education*. Englewood Cliffs, N.J.: Educational Technology Publications, 1971.

* Rawson-Jones, D. *Communicating Family Planning*. London: International Planned Parenthood Federation, 1971.

Rogers, E. *Communication Strategies for Family Planning*. New York: The Free Press, 1973.

*Highly recommended by Planned Parenthood of Maryland, Inc., Family Planning Training Institute.

Booklets and Pamphlets:

Berndtson, B. "Development of Family and Population Planning Communication Material." Honolulu, Hawaii: East-West Communication Institute Publications, 1972.

"A First Priority: Family Planning Communication Through Printed Material. Requirements for Preparation and Production of Printed Material." Honolulu, Hawaii: East-West Communication Institute Publications.

"Guide to Audio-Visual Aids for Spanish-speaking Americans." Rockville, Maryland: DHEW. (HSM) 74-30. 1973.

"Spanish Language Health Communication Teaching Aids." Rockville, Maryland: DHEW. (HSM) 73-19. 1973.

"The Planning, Preparation, and Production of Audio-Visual Material." Honolulu, Hawaii: East-West Communication Institute Publications.

"Visual Materials: Guidelines for Selection and Use in Training Situations." Washington, D.C.: U.S. Civil Service Commission. December, 1971.

Films and Other Audio-Visual Materials:

Family Planning: More Than a Method. Documentary with broad appeal for general public and community education. 27 min., B & W, 16 mm. The National Audio-Visual Center, 1971.

Journal Articles:

Dabbs, K. "Family Planning Hotline." *Family Planning Perspectives*, II (January, 1970), 13-4.

Elliott, R. "Advertising Family Planning." *Family Planning Perspectives*, III (October, 1971), 65-7.

Schramm, W. "Communication in Family Planning." *Reports on Population / Family Planning*, VII (April, 1971), 1-43.

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Books:

Calderone, M.S., ed. *Manual of Family Planning and Contraceptive Practice*. 2nd ed. Baltimore, Maryland: Williams and Wilkins Co., 1970.

Choosing a Birth Control Method. St. Louis, Missouri: The Emko Company.

Demarest, R.J. and J.J. Sciarra. *Conception, Birth and Contraception—A Visual Presentation*. New York: McGraw-Hill Book Co., 1969.

Booklets and Pamphlets:

"A Woman's Guide to the Methods of Postponing or Preventing Pregnancy." Raritan, New Jersey: Ortho Pharmaceutical Company.

"Basics of Birth Control." New York: Planned Parenthood-World Population.

"Birth Control." New York: Community Sex Information and Education Service, 1971.

"Birth Control: All the Methods That Work and the Ones That Don't." Brooklyn, New York: Family Planning Resources Center.

"Birth Control Handbook." Montreal, Canada: Birth Control Handbook, 1973.

Brosemer, A. "Sex Without Side Effects." Sacramento, California: Planned Parenthood Association of Sacramento, 1972.

Cherniak, D. and A. Feingold. "Birth Control Handbook." Montreal, Canada: Birth Control Handbook, 1972.

"Commentaires sur la Contraception Steroidale." London, England: International Planned Parenthood Federation, 1971.

*"Contraceptive Technology, 1974." Atlanta, Georgia: Emory University Family Planning Program.

"El Don De La Vida." New York: Planned Parenthood-World Population.

"Elephants and Butterflies and Contraceptives." Chapel Hill, North Carolina: University of North Carolina Press, 1971.

"Entre Mama Entre Papa." Boston, Mass.: Pathfinder Fund.

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"Intrauterinos." New York: Planned Parenthood-World Population.

"La Sortija de Compromiso, Una Foto-Novela." New York: Planned Parenthood-World Population.

"Le planning familial pour les sages—femmes et les enfirmieres." London, England: International Planned Parenthood Federation, 1971.

"Methods of Conception Control" Raritan, New Jersey: Ortho Pharmaceutical Corporation, 1972.

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"Preguntas y Respuestos." New York: Planned Parenthood-World Population.

"Preguntas y Respuestos las Pastellas Anticonceptivas." New York: Planned Parenthood-World Population.

"Preguntas y Respuestos Sobre Los Dispositivos Intrauterinos." New York: Planned Parenthood-World Population, 1971.

"Research in Reproductive Biology and Contraceptive Technology." New York: Ford Foundation Reprints.

"Ser Padre, Ser Madre." New York: Planned Parenthood-World Population.

"She Will Always Remember You." Denver, Colorado: Rocky Mountain Planned Parenthood, 1970.

"Sobre Los Dispositivos." New York: Planned Parenthood-World Population.

"Stop Kidding Yourself." Denver, Colorado: Rocky Mountain Planned Parenthood.

"Ustedes Pueden Planear Su Familia." New York: Planned Parenthood-World Population.

*Highly recommended for staff training.

Comic Books:

Amor Sin Temor. New York, New York: Planned Parenthood-World Population.

Antes Que Sea Tarde. New York, New York: Information Materials Press.

Corazones en Conflicto. New York, New York: Information Materials Press.

El Doble Dilema. New York, New York: Information Materials Press.

Escape from Fear. New York, New York: Planned Parenthood-World Population, 1962.

"Facts O'Life Funnies." San Francisco: Multi-Media Resource Center.

Films and Other Audio-Visual Materials:

About Sex. Teenagers discuss contraception and human sexuality. 23 min., color, 16 mm. Texture Films, Inc., 1972.

Hope Is Not a Method. Methods description; designed for college students, but good for all audiences. 15 min., color, 16 mm., 8 mm., Planned Parenthood Center of Syracuse, Inc., 1973.

How Many Children Do You Want?: I. How Babies Begin, II. Doctor Methods of Birth Control, III. Drugstore Methods of Birth Control and Least Effective Methods. Methods and reproduction descriptions; rural setting. 13 min. each, filmstrip and record. Educational Materials Unit, Carolina Population Center, 1971.

It's My Turn. Methods description; discussion among six women on attitudes, motivation. 20 min., B & W, 16 mm. A.I.M. Films, 1972.

A Matter of Choice. Methods description. 20 min., color, 16 mm., 8 mm., Super 8. Planned Parenthood-World Population, 1973.

Methods of Family Planning. Methods description including sterilization. Discusses pros and cons of methods. 18 mm., color, 16 mm., Oxford Films, Inc., 1972.

Miscellaneous Materials:

Betsi: Breast model. Raritan, New Jersey: Ortho Pharmaceutical Company. (New model with additional lesions is now available.)

Choosing a Birth Control Method. Flip-chart. St. Louis: The Emko Company.

Gynny: Pelvic Model. Raritan, New Jersey: Ortho Pharmaceutical Company.

It's Up to You. Flip-chart. Prince George's County Health Department, Maryland.

Understanding Family Planning. Flip-chart. Raritan, New Jersey: Ortho Pharmaceutical Company.

Feminist Movement

Books:

Frankfort, E. *Vaginal Politics*. New York: Bantam Books, 1973.

Our Bodies, Our Selves. New York: Boston Women's Health Book Collective, Simon and Schuster, 1973.

Booklets and Pamphlets:

"Family Life Education Curriculum Guide." California Youth Authority, January, 1974. State of California Documents Section, Sacramento.

"So You Don't Want to Be a Sex Object." Denver, Colorado: Rocky Mountain Planned Parenthood, 1973.

Films and Other Audio-Visuals:

Menstruation. Light and humorous. Combination of animation and acting explains the menstrual cycle and many of the attendant feelings about menstruation. 18 min., color, 16 mm. Phoenix Films, 1974.

Journal Articles:

Muller, C.F. "Feminism, Society and Fertility Control." *Family Planning Perspectives*, VI, 2 (Spring 1974), p. 68-73.

Foreign Language Materials

Booklets and Pamphlets:

"Abortion" (Spanish edition). London, England: International Planned Parenthood Federation.

"Aborto." Brooklyn, New York: Family Planning Resources Center Publications.

"Commentaires sur la Contraception Steroidale." London, England: International Planned Parenthood Federation, 1971.

"El Don De La Vida." New York: Planned Parenthood-World Population.

"Entre Mama Entre Papa." Boston, Mass.: Pathfinder Fund.

"Esterilizacion Voluntaria Para Hombres Y Mujeres." New York: Planned Parenthood-World Population.

"Intrauterinos." New York: Planned Parenthood-World Population.

"L'avartement provoque." London, England: International Planned Parenthood Federation, 1972.

"La Rapport entre la Faille de la Familie et la sante de la mire et de l'enfant." London, England: International Planned Parenthood Federation, 1970.

"La Sortija de Compromiso, Una Foto-Novela." New York: Planned Parenthood-World Population.

"Le planning familial pour les sages—femmes et les enfirmieres." London, England: International Planned Parenthood Federation, 1971.

"Metodo del Ritmo." New York: Planned Parenthood-World Population.

"Metodos Anticonceptivos Modernos." New York: Planned Parenthood—World Population.

"Preguntas y Respuestos." New York: Planned Parenthood-World Population.

"Preguntas y Respuestos las Pastellas Anticonceptivas." New York: Planned Parenthood-World Population.

"Ser Padre, Ser Madre." New York: Planned Parenthood-World Population.

"Sobre Los Despositivos." New York: Planned Parenthood-World Population.

"Spanish Language Health Communication Teaching Aids." Rockville, Maryland: DHEW, (HSM) 73-A, 1973.

"Syllabaire de la Femme enceinte et de la Nouvelle Accouchee." Port-au-Prince, Haiti: Centre D'Hygiene Familiale, Pathfinder Fund, 1969.

"Syllabaire du Bebe." Port-au-Prince, Haiti: Centre D'Hygiene Familiale, Pathfinder Fund.

"Ustedes Pueden Planear Su Familia." New York: Planned Parenthood-World Population.

"Vasectomy" (Spanish). London, England: International Planned Parenthood Federation.

Comic Books:

Amor Sin Temor. New York, New York: Planned Parenthood-World Population.

Antes Que Sea Tarde. New York, New York: Information Materials Press.

Corazones en Conflicto. New York, New York: Information Materials Press.

El Doble Dilema. New York, New York: Information Materials Press.

Men

Books:

Gillette, P. J. *The Vasectomy Information Manual*. New York: Outerbridge & Lazard, Inc., 1972.

Booklets and Pamphlets:

"About Boys." Baltimore, Maryland: Planned Parenthood Association of Maryland.

"For Men Only." Tulsa, Oklahoma: Tulsa City-County Health Department.

"Masturbation." New York: Community Sex Information and Education Service, 1971.

"The Combination." Denver, Colorado: Rocky Mountain Planned Parenthood.

"The Man's World: Sex / Anatomy / Birth Control / V.D. / The Condom." Chapel Hill, North Carolina: Population Services International.

"Vasectomy." Denver, Colorado: Rocky Mountain Planned Parenthood.

"The View From Our Side." Atlanta, Georgia: Emory Univeraity.

"What Every Man Should Know About Birth Control." New York: Planned Parenthood-World Population.

"When You Don't Make It." San Francisco: Multi-Media Resource Center (on secondary impotence).

"You Can Last Longer." San Francisco: Multi-Media Resource Center (on premature ejaculation).

Films and Other Audio-Visual Materials:

Freedom from Pregnancy. Facts about tubal ligation and vasectomy. 11 min., color, 16 mm., 8 mm., Super 8. Allend'or Productions, 1970.

Menstruation. Light and humorous. Combination of animation and acting explains the menstrual cycle and many of the attendant feelings about menstruation. Excellent for educating and sensitizing males. 18 min., color, 16 mm. Phoenix Films, 1974.

Vasectomy. Discussion with vasectomized men and their wives. 17 min., color, 16 mm., Churchill Films, 1972.

Journal Articles:

Leader, A.J. "The Houston Story: A Vasectomy Service in a Family Planning Clinic." *Family Planning Perspectives, III* (July, 1971), 46-9.

Mentally Retarded

Books:

Bass, M.S. *Developing Community Acceptance of Sex Education for the Mentally Retarded*. New York: SIECUS, 1972.

Booklets and Pamphlets:

"A Resource Guide in Sex Education for the Mentally Retarded." New York: SIECUS.

Kempton, W., M. Bass and S. Gordon. "Love, Sex and Birth Control for the Mentally Retarded—A Guide for Parents." New York: Planned Parenthood-World Population, 1973.

Gordon, S. "Sexual Rights for the People . . . Who Happen to be Handicapped." Syracuse, New York: Center on Human Policy, Syracuse University, 1974.

Films and Other Audio-Visual Materials:

Mental Retardation and Human Sexuality. How to teach human sexuality to the mentally retarded. 20 min., filmstrip. Planned Parenthood of S.E. Pennsylvania, 1971.

Journal Articles:

Pallister, P.D. "Reflections on Marriage for the Retarded: The Case for Voluntary Sterilization." *Hospital and Community Psychiatry*, XXIV (March, 1973), 172-4.

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Booklets and Pamphlets:

Bogue, D.J., ed. "Family Planning Improvement Through Evaluation: A Manual of Basic Principles." Chicago, Illinois: Community and Family Study Center, University of Chicago, 1970.

"A Model for Planning Patient Education." Rockville, Maryland: HSMHA-HEW, (HSM 72-4023), 1972.

Young, R. and A. Zawacki. "Working Through Community Institutions for Family Planning." Chicago, Illinois: Community and Family Study Center, University of Chicago, 1969.

Journal Articles:

Arnold, C.B., et al. "Interorganization Cooperation for Family Planning Referral in Wake County, North Carolina." *Family Planning Perspectives*, II (March, 1970), 42-6.

Beasley, J.D., R.F. Frankowski, and C.M. Hawkins. "Evaluation of National Health Programs. IV. Louisiana Family Planning." *American Journal of Public Health*, LXI (September, 1971), 1812-25.

Beasley, J.D. and J.P. Wells. "Louisiana: Developing and Managing a Statewide Family Planning Program." *Family Planning Perspectives*, III (October, 1971), 68-79.

Beasley, W.B.R. "Coping with Family Planning in a Rural Area." *Obstetrics and Gynecology*, XL (January, 1973), 155-9.

Bradshaw, B.R. and C.B. Mapp. "Consumer Participation in a Family Planning Program." *American Journal of Public Health*, LXII (July, 1972), 969-72.

Cochrane, C.M., C.E. Vincent, C.A. Haney, and R. Michielutte. "Motivational Determinants of Family Planning Clinic Attendance." *Journal of Psychology*, LXXXIV (May, 1973), 33-43.

Fischman, S.H., S.H. Katz, and S.G. Sprague. "The Development of a Family Planning Program for Private Patients in a Community Hospital." *American Journal of Public Health*, LXI (October, 1971), 2023-30.

Furstenburg, F.F., Jr., G.S. Masnick, and S.A. Ricketts. "How Can Family Programs Delay Repeat Teenage Pregnancies?" *Family Planning Perspectives*, IV (July, 1972), 54-60.

Goldsmith, S. "San Francisco's Teen Clinics: Meeting the Sex Education and Birth Control Needs of the Sexually Active School Girl." *Family Planning Perspectives*, I (No. 2, 1969), 32.

Goldstein, H. "Observations on Evaluation of Family Planning Programs." *Health Service Reports*, LXXXVIII (March, 1973), 213-7.

Gordis, L., et al. "Evaluation of a Program for Preventing Adolescent Pregnancy." *New England Journal of Medicine*, CCLXXXII (May, 1970), 1078-81.

Jolly, D., et al. "Research in the Delivery of Female Health Care: The Recipients' Reaction." *American Journal of Obstetrics and Gynecology*, CX (June, 1971), 291-4.

Kangas, L.W. "Integrated Incentives for Fertility Control." *Science*, CLXIX (September 25, 1970), 1278-83.

Klein, S.F. "Toward a Framework for Evaluating Health Education Activities of a Family Planning Program." *American Journal of Public Health*, LXI (June, 1971), 1096-109.

Munroe, G.S. and G.W. Jones. "Mobile Units in Family Planning." *Reports on Population/Family Planning*, X (October, 1971), 1-32.

O'Connor, R.W., et al. "Planning and Implementing a Large-Scale Family Planning Program in Georgia." *American Journal of Public Health*, LX (January, 1970), 78-86.

O'Connor, R.W. and G.L. Urban. "Using a Model as a Practical Management Tool for Family Planning Programs." *American Journal of Public Health*, (November, 1972), 1493-500.

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Pomeroy, R. and A. Torres. "Family Planning Practices of Low Income Women in Two Communities." *American Journal of Public Health*, LXII (August, 1972), 1123-9.

"Prospectus: Workshop for Participants in Population / Family Planning Communication for Persons Actively Engaged in Information Education and Communication Roles Concerning Population and Family Planning." Honolulu, Hawaii: East-West Communication Institute Publications, 1973.

Reynolds, J. "Evaluation of Family Planning Program Performance: A Critical Review." *Demography*, 9 (February, 1972), 69-86.

Seltzer, W. "Measurement of Accomplishment: The Evaluation of Family Planning Efforts." *Studies in Family Planning*, # 33 (May, 1970).

Sieverts, S. "Program Planning for Family Planning Services." *Family Planning Perspectives*, II (March, 1970), 2-5.

Speidel, J.J. and L. Wiener. "Continuance of Family Planning in a Health Department Clinic." *American Journal of Obstetrics and Gynecology*, CVIII (December 1, 1970), 1134-40.

Tamblyn, P.B., R.H. Richardson and E.S. Ruyle. "Planning for Family Planning." *American Journal of Public Health*, LXIII (February, 1973), 142-3.

"The Report of the President's Committee on Health Education." New York: President's Committee on Health Education, 1973.

Tyler, C.W., Jr., and J.C. Smith. "Family Planning Program Evaluation By Use of a Sample Survey: The Emory University Family Planning Program, Atlanta, Georgia." *American Journal of Public Health*, LX (July, 1970), 1254-70.

Tyler, C.W., Jr., et al. "Assessment of a Family Planning Program: Contraceptive Services and Fertility in Atlanta, Georgia." *Family Planning Perspectives*, II (March, 1970), 25-9.

Weinberg, D. "What State Governments Can Do." *Family Planning Perspectives*, II (March, 1970), 30-4.

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Books:

*Andry, A.C. and S. Schepp. *How Babies Are Made*. New York: Time-Life Books, 1968.

Bell, R. and M. Gordon, eds. *The Social Dimension of Human Sexuality*. Boston: Little, Brown and Co., 1972.

**Bergstrom-Walan, M. *Boys and Girls Growing Up*. Belmont, California: Fearon, 1965.

Broderick, C.B. and J. Bernard, eds. *The Individual, Sex and Society*. Baltimore, Maryland: Johns Hopkins Press, 1969.

*Evans, E.K. *The Beginning of Life: How Babies Are Born*. New York: Crowell-Collier, 1969.

Gordon, S. *Facts About Sex for Today's Youth: A Basic Guide*. New York: John Day Co., 1970.

**Gruenberg, B.C. and S.M. *The Wonderful Story of How You Were Born*. Garden City, New York: Doubleday, 1970.

Guttmacher, Alan F. *Understanding Sex: A Young Person's Guide*. New York: Harper & Row Publishers, Inc., 1970.

Katchadourian, H. and D. Lunde. *Fundamentals of Human Sexuality*. New York: Holt, Rinehart, and Winston, Inc., 1972.

**Levine, M.I. and J. Seligman. *The Wonder of Life*. New York: Golden Press, 1964.

Masters, W.H. and V.E. Johnson. *Human Sexuality Inadequacy*. Boston: Little, Brown & Co., 1970.

**May, J. *How We Are Born*. Chicago: Follett, 1969.

**Navarra, J.G., J.S. Weisberg and F. Mele. *From Generation to Generation, the Story of Reproduction*. Garden City, New York: Doubleday, 1970.

Netter, J.N. *The CIBA Collection of Medical Illustrations: Reproductive System*. Rev. ed. Vol. 2. Newark, New Jersey: CIBA, 1965.

Osofsky, H. and J. *Let's Be Sensible About Sex Education*. New York: Ed-U Press.

Our Bodies, Our Selves. New York: Boston Women's Health Book Collective, Simon and Schuster, 1973.

Rubin, I. and L. Kirkendall, eds. *Sex in Childhood Years*. New York: Association Press, 1970.

*Schima, M. and P. Bollan. *The Magic of Life*. Englewood Cliffs, N.J.: Prentice-Hall, 1970.

**de Schweinitz, K. *Growing Up*. New York: Macmillan, 1965.

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SIECUS. *Sexuality and Man*. New York: Charles Scribner's Sons, 1970.

**Strain, F.B. *Being Born*. New York: Hawthorn Books, 1970.

**Widerberg, S. *The Kid's Own XYZ of Love and Sex*. New York: Stein and Day, 1972.

*Recommended for 3-6 year olds.
**Recommended for 6-13 year olds.

Booklets and Pamphlets:

"A Doctor Talks to 9-12 Year Olds." Detroit, Michigan: Planned Parenthood League.

"About Boys." Baltimore, Maryland: Planned Parenthood Association of Maryland.

"A Basic List of Sex Education and Population Resource Ideas." New York: Ed-U Press.

"As You Become a Woman." Baltimore, Maryland: Planned Parenthood Association of Maryland.

"Family Life Education Curriculum Guide." California Youth Authority, January, 1974. State of California Documents Section, Sacramento.

Hofstein, S. "Talking to Preteenagers about Sex." New York: SIECUS.

"Homosexuality." New York: Community Sex Information and Education Service. 1971.

"How to Tell Your Children About Sex." New York: Community Sex Information and Education Service. 1971.

"Love Making." New York: Community Sex Information and Education Service. 1971.

"Masturbation." New York: Community Sex Information and Education Service. 1971.

"Masturbation Techniques for Women." San Francisco: Multi-Media Resource Center.

"Sex: A Better Understanding." New York: Community Sex Information and Education Service. 1971.

"Sex Education Neglected Youth." New York: Ed-U Press.

"Sex Outside Marriage." New York: Community Sex Information and Education Service. 1971.

"So You Don't Want to be a Sex Object." Denver, Colorado: Rocky Mountain Planned Parenthood. 1973.

"This is You." Denver, Colorado: Rocky Mountain Planned Parenthood. 1973.

*Highly recommended.

Films and Other Audio-Visual Materials:

About Sex. Teenagers discuss contraception and human sexuality. 23 min., color, 16 mm., Texture Films, Inc., 1972.

Becoming a Man: Becoming a Woman. I: Male, II: Female. Describes physical and psychological changes; includes human sexuality. 8 mm. (I), 14 min. (II), color, filmstrip and record. Guidance Associates, Inc.

Love Toad. Animated stuffed toads making love to music; no dialogue. May be considered "adult;" good to precede human sexuality discussion. 2 min., color, 16 mm. Multi-media Resource Center, 1971.

Menstruation. Light and humorous. Combination of animation and acting explains the menstrual cycle and many of the attendant feelings about menstruation. Excellent for parents as well as younger audiences. 18 min., color, 16 mm. Phoenix Films, 1974.

Old Enough to Know. Parental discussion of sex education for children. 20 min., color, 16 mm. Planned Parenthood Center of Seattle, Inc., 1972.

Journal Articles:

Veerhusen, P., P. Cooksey, and D. Fredlund. "Pregnancy: A Crisis in Health Education." American Journal of Public Health, LXII (June, 1972), 821-3.

Staff Training

Books:

Haselkorn, F., ed. *Family Planning: Readings and Case Materials*. New York: Council on Social Work Education, 1971.

Manisoff, M. T. *Family Planning: A Teaching Guide for Nurses*. 2nd ed. New York: Planned Parenthood-World Population, 1971.

Family Planning Training for Social Service. New York: Planned Parenthood-World Population, 1970.

Schiller, P. *Creative Approach to Sex Education and Counseling*. New York: Association Press, 1973.

Whelan, E.M., and M.G. Quadland. *Human Reproduction and Family Planning: A Programmed Text*. Palo Alto, Calif.: Syntex Laboratories, Inc., 1972.

Zawacki, A.A. *A Textbook for Family Planning Field Workers*. Chicago, Illinois: University of Chicago Press, 1971.

Booklets and Pamphlets:

Bean, L., R.K. Anderson, and H.J. Tatum. "Manpower and Training: An Occasional Paper of the Population Council." Bridgeport, Connecticut: Key Book Service, Inc., 1971.

"Consultation, Training, and Support Materials from Cornell University and Other Institutions and Agencies for Cooperative Extension Programs in Population, Family Planning, and Sex Education." Ithaca, New York: COSPA/NY, 1973.

* "Contraceptive Technology, 1974." Atlanta, Georgia: Emory University Family Planning Program, 1973-74.

* "Family Life Education Curriculum Guide." California Youth Authority, January, 1974. State of California Documents Section, Sacramento.

"Family Planning with the Pill: A Manual for Nurses." Chicago, Illinois: G.D. Searle Company.

"Family Planning Words." Atlanta, Georgia: Regional Training Center, 1973.

"For Case Workers: Experience in Counseling Birth Control." Denver, Colorado: Rocky Mountain Planned Parenthood.

"Outreach for Family Planning: A Counseling Guide." Denver, Colorado: Rocky Mountain Planned Parenthood.

"Patient Services Training Manual." San Francisco, California: Alameda-San Francisco Planned Parenthood-World Population, 1973.

"The Professional Training and Preparation of Sex Educators." American Association of Sex Educators and Counselors, Washington, D.C., 1972.

*Highly recommended.

Films and Other Audio-Visual Materials:

Abortion Without Cervical Dilation. Covers counseling, suction aspiration technique and procedure, and follow-up counseling. For professional audiences only. 12 min., color, 16 mm. C.O.R.T. Motion Pictures, 1971.

Family Planning: The Louisiana Model. Description of a community and state-wide planning process of building a family planning program. 17 min., B & W, 16 mm. Planned Parenthood-World Population, 1970.

It Won't Be Easy. Documentary of para-professional training. 34 min., B & W, 16 mm. The National Audio-Visual Center, 1971.

**Menstruation*. Light and humorous. Combination of animation and acting explains the menstrual cycle and many of the attendant feelings about menstruation. 18 min., color, 16 mm. Phoenix Films, 1974.

Mental Retardation and Human Sexuality. How to teach human sexuality to the mentally retarded. 20 min., filmstrip. Planned Parenthood of S.E. Pennsylvania, 1971.

Not As a Privilege. Deals with relationships among family planning staff and clients. 29 min., color, 16 mm. Motion Picture Labs, Inc., 1970.

Nurse's Training Filmstrip. Nurses' roles and techniques used in family planning. 14 min., color, filmstrip and record.

Pregnancy and Abortion Counseling: Selected Role Plays. Training counselors for teenagers. 50 min., (2 reels), B&W, 16 mm., Planned Parenthood-World Population, 1972.

Termination with Safety. Technique of vacuum aspiration. For professional audiences only. 27 min., color, 16 mm. The Lalor Foundation, 1972.

Journal Articles:

"A Family Planning Glossary." *Family Digest*, November, 1973.

Ostergard, D.R., E.M. Broen, and J.R. Marshall. "The Family Planning Specialist." *Clinical Obstetrics and Gynecology*, XV (June, 1972), 370-8.

Smith, E. "Family Planning Coordinator in a City Hospital." *American Journal of Nursing*, LXX (November, 1970), 2362-5.

Miscellaneous materials:

Methods of Contraception (including Reproductive Anatomy and Physiology). Flip-chart. Department of Training, Planned Parenthood-World Population.

Teenagers

Books:

Gordon, S. *Facts About Sex for Today's Youth*. New York: Ed-U Press.

Facts About VD for Today's Youth. New York: The John Day Company, 1973.

Psychology for You. New York: Oxford Book Company, 1973.

The Sexual Adolescent. North Scituate, Mass.: Duxbury Press, 1973.

Guttmacher, A.F. *Understanding Sex: A Young Person's Guide*. New York: Harper & Row Publishers, Inc., 1970.

Kantner, J.F. and M. Zelnik. "Sex and Contraception Among Unmarried Teenagers." *Toward the End of Growth*. Edited by C.F. Westoff. New York: Spectrum Books, 1973.

Pierce, R.I. *Single and Pregnant*. Boston, Mass.: Beacon Press, Inc., 1970.

Rubin, I. and ". Kirkendall, eds. *Sex in Childhood Years*. New York: Association Press, 1970.

Booklets and Pamphlets:

"A Doctor Talks to 9-12 Year Olds." Detroit, Michigan: Planned Parenthood League.

"Early Sexual Experiences." New York: Community Sex Information and Education Service, 1971.

"Family Life Education Curriculum Guide." California Youth Authority, January, 1974. State of California Documents Section, Sacramento.

Gordon, S. "Protect Yourself from Becoming an Unwanted Parent." New York: Ed-U Press.

"Ten Heavy Facts About Sex." New York: Ed-U Press, 1971.

"V.D. Claptrap." New York: Ed-U Press.

Guttmacher, A. "The Doctor Talks About Birth Control: A Teenage Fact Book." New York: Planned Parenthood-World Population.

Hofstein, S. "Talking to Preteenagers about Sex." New York: SIECUS.

"How to Tell Your Children About Sex." New York: Community Sex Information and Education Service, 1971.

Irwin, T. "The Rights of Teenagers as Patients." New York: SIECUS.

"Planning Your Family." New York: Ed-U Press.

Sarrel, P. "Teenage Pregnancy: Prevention and Treatment." SIECUS Study Guide No. 14.

"Sex in a Plain Brown Wrapper." New York: Ed-U Press.

"What Adolescents Want to Know." New York: Ed-U Press.

"What's Happening?" Atlanta, Georgia: Emory University Family Planning Program. (Popular magazine format.)

Films and Other Audio-Visual Materials:

About Sex. Teenagers discuss contraception and human sexuality. 23 min., color, 16 mm., Texture Films, Inc., 1972.

Becoming a Man: Becoming a Woman. I: Male, II: Female. Describes physical and psychological changes, includes human sexuality. 8 min. (I), 14 min. (II), color, filmstrip and record. Guidance Associates, 1971.

A Chance of Love. Set in inner-city; communications and birth control problems of a young black couple. 24 min., B&W, 16 mm. Cine-Image Films, 1972.

Half-Million Teenagers. Venereal disease discussion: symptoms, spread, treatment. 17 min., 16 mm. Churchill Films, 1972.

I'm 17, I'm Pregnant . . . And I Don't Know What to Do. Problems of teenage pregnancy. 28 min., color, 16 mm. Children's Home Society of California, 1972.

Menstruation. Light and humorous. Combination of animation and acting explains the menstrual cycle and many of the attendant feelings about menstruation. 18 min., color, 16 mm. Phoenix Films, 1974.

Pregnancy and Abortion Counseling: Selected Role Plays. Training counselors for teenagers. 50 min. (2 reels), B&W, 16 mm. Planned Parenthood-World Population, 1972.

Too Soon Blues. Inner city setting. Conflicts of a young black girl about sex and contraception. 24 min., color, 16 mm. Cine-Image Productions, Ltd., 1972.

VD — A New Focus. VD: myths, facts, attitudes, symptoms and treatment. Focuses on adolescents. 16 min., color, 16 mm. American Educational Films.

Young, Single and Pregnant. I. Discussion of pregnancy and contraception; attitudes and motivations. II. Discussion of the problems and decisions faced by pregnant girls. 7 min. (I), 8 min. (II) color, filmstrip. Guidance Associates, 1972.

Journal Articles:

Cassidy, J.T. "Teenagers in a Family Planning Clinic." *Nursing Outlook*, XVIII (November, 1970), 30-1.

Furstenberg, F.F., Jr., G.S. Masnick and S.A. Ricketts. "How Can Family Programs Delay Repeat Teenage Pregnancies?" *Family Planning Perspectives*, IV (July, 1972), 54-60.

Gabrielson, I., S. Goldsmith, et al. "Adolescents' Attitudes Toward Abortion." *American Journal of Public Health*, Vol. 61, No. 4, 730.

Goldsmith, S. "San Francisco's Teen Clinics: Meeting the Sex Education and Birth Control Needs of the Sexually Active School Girl." *Family Planning Perspectives*, IV (No. 1, 1972), 23.

Goldsmith, S. and D. Minkler. "Preventive Medicine for Teenagers — Clinics for Sex Education and Birth Control." *Advances in Planned Parenthood*, V, 1970, 71.

Goldsmith, S., et al. "A Study of Teenage Contraceptors: Their Knowledge, Attitudes and Use of Birth Control." *Advances in Planned Parenthood*, in press.

Goldsmith, S. et al. "Teenagers, Sex and Contraception." *Family Planning Perspectives*, IV (No. 1, 1972), p. 32.

Gordis, L. et al. "Evaluation of a Program for Preventing Adolescent Pregnancy." *New England Journal of Medicine*, CCLXXXII (May, 1970), 1178-81.

Kantner, J. F. and M. Zelnik. "Contraception and Pregnancy: Experience of Young Unmarried Women in the United States." *Family Planning Perspectives*, V (No. 1, 1973).

Kantner, J. F. and M. Zelnik. "Sexual, Contraception and Pregnancy Experience of Young Unmarried Women in the United States." *Family Planning Perspectives*, IV (No. 4, 1972).

Menken, J. A. "Teenage Childbearing: Its Medical Aspects and Implications for the United States Population." Commission on Population and the American Future, *Demographic and Social Aspects of Growth*, 1972.

Morris, L. "Estimating the Need for Family Planning Services Among Unwed Teenagers." *Family Planning Perspectives*, VI (No. 2, 1974), 91.

Pipel, H F. and N.F. Wechsler. "Birth Control, Teenagers and the Law: A New Look, 1971." *Family Planning Perspectives*, III (July, 1971), 37.

Zelnik, M. and J. F. Kantner. "The Resolution of Teenage First Pregnancies." *Family Planning Perspectives*, VI (No. 2, 1974), 74.

Venereal Disease

Books:

Gordon, S. *Facts About Sex for Today's Youth*. New York: John Day, 1973.

Booklets and Pamphlets:

"Facts You Should Know about VD, but Probably Don't." New York: Metropolitan Life Insurance Company, 1971.

"Gays Get It, Too!" Atlanta, Georgia: Georgia Gay Liberation Front.

"VD Handbook." Montreal, Canada: Birth Control Handbook, 1972.

"What Everyone Should Know About VD." Massachusetts: Channing L. Bete Company, Inc., 1971.

Films and Other Audio-Visual Materials:

Half-Million Teenagers. Discussion of VD: symptoms, spread, treatment. 17 min., color, 16 mm. Churchill Films, 1972.

VD — A New Focus. VD: myths, facts, attitudes, symptoms and treatment. Focuses on adolescents. 16 min., color, 16 mm. American Educational Films, 1972.

Voluntary Sterilization

Books:

Gillette, P. J. *The Vasectomy Information Manual*. New York: Outerbridge & Lazard, Inc., 1972.

Booklets and Pamphlets:

"Esterilizacion Voluntaria Para Hombres Y Mujeres." New York: Planned Parenthood-World Population.

"Know Your Rights About Voluntary Sterilization." New York: Association for Voluntary Sterilization, Inc.

"Laparoscopy." Chapel Hill, North Carolina: Carolina Population Center.

"Vasectomy." Chapel Hill, North Carolina: Carolina Population Center.

"Vasectomy (Spanish)." London, England: International Planned Parenthood Federation.

Films and Other Audio-Visual Materials:

Freedom from Pregnancy. Facts about tubal ligation and vasectomy. 11 min., color, 16 mm., 8 mm., Super 8. Allend'or Productions, 1970.

Vasectomy. Discussion with vasectomized men and their wives. 17 min., color, 16 mm., Churchill Films, 1972.

Journal Articles:

Elstein, M. "Sterilization and Family Planning." *Practitioner*, CCV (July, 1970), 30-7.

Leader, A.J. "The Houston Story: A Vasectomy Service in a Family Planning Clinic." *Family Planning Perspectives*, III (July, 1971), 46-9.

Pallister, P.D. "Reflections on Marriage for the Retarded: The Case for Voluntary Sterilization." *Hospital and Community Psychiatry*, XXIV (March, 1973), 172-4.

4.3 Publishers and Suppliers of Family Planning Materials

This section provides the addresses of many of the publishers and suppliers of materials listed in Section 4.2.

A.I.M. Films
25 S. Bemiston, Suite 202
Clayton, Missouri 63105

Allend'or Productions
4321 Woodman Ave.
Sherman Oaks, California 91403

American Association of Sex Educators and Counselors
3422 N Street, N.W.
Washington, D.C.

American Educational Films
132 Lasky Dr.
Beverly Hills, California 90212

American Public Health Association
1015 18th Street, N.W.
Washington, D.C. 20036

Association for Voluntary Sterilization, Inc.
14 West 40th Street
New York, N.Y. 10018

Association Press
291 Broadway
New York, N.Y. 10007

Bantam Books
271 Madison Avenue
New York, N.Y. 10016

Beacon Press, Inc.
25 Beacon Street
Boston, Massachusetts 02108

Berkeley Bio-Engineering, Inc.
1215 4th St.
Berkeley, California 94710

Birth Control Handbook
P.O. Box 1000
Station G
Montreal 130, Quebec, Canada

Cambridge University Press
32 East 57th Street
New York, N.Y. 10022

Carolina Population Center
University of North Carolina
Chapel Hill, N.C.

Chandler Publishing Co.
124 Spear Street
San Francisco, California 94105

Chestergate House
Vauxhall Bridge Road
London, England

Children's Home Society of California
3100 W. Adams Blvd.
Los Angeles, California 90018

Churchill Films
622 N. Robertson Blvd.
Los Angeles, California 90069

CIBA
P.O. Box 1340
Newark, N.J. 07101

Cine-Image Films
3929 Maquoketa Drive
Des Moines, Iowa 50311

Community and Family Study Center
1411 East 60th Street
Chicago, Illinois 60637

Community Sex Information and Education Service
P.O. Box 2858
Grand Central Station
New York, N.Y. 10017

C.O.R.T. Motion Pictures
University of California
532A Parnassus Ave.
San Francisco, California 94122

COSPA, NY
Graduate Training and Research Center
Department of Communication Arts
Cornell University
640 Stewart Avenue
Ithaca, New York

Council on Social Work Education
345 East 46th Street
New York, N.Y. 10017

John Day Company
62 W. 45th Street
New York, N.Y. 10036

Doubleday & Company, Inc.
501 Franklin Avenue
Garden City, N.Y. 11530

Duxbury Press
6 Bound Brook Court
North Scituate, Mass. 02060

Educational Materials Unit
Carolina Population Center
214 W. Cameron Ave.
Chapel Hill, N.C. 27514

Educational Technology
Englewood Cliffs, N.J. 07632

Ed-U-Press
760 Ostrom Avenue
Syracuse, N.Y. 13210

The Emko Company
7912 Manchester Avenue
St. Louis, Missouri 63143

Emory University Family Planning Program
69 Butler Street
Atlanta, Georgia 30303

Family Planning Training Institute
Planned Parenthood Association of Maryland
24 W. Franklin Street
Baltimore, Maryland 21201

Family Planning Resources Center
44 Court Street
Brooklyn, N.Y. 11201

Federal Marketing Service
P.O. Box 7316
Alexandria, Virginia 22307

Free Press
Macmillan Co.
866 Third Avenue
New York, N.Y. 10022

Ford Foundation Reprints
Office of Reports
320 E. 43rd Street
New York, N.Y. 10017

Georgia Gay Liberation Front
Box 7974
Atlanta, Georgia 30309

Guidance Associates
Pleasantville, N.Y. 10570

Harper & Row Publishers, Inc.
Scranton, Pa. 18512

Health Resources Administration (DHEW)
Health Care Facilities Service
Office of Education and Training
5600 Fishers Lane
Rockville, Maryland 20852

Health Services Administration (DHEW)
Program Services Branch
Bureau of Community Health Services
Room 12 A-33
5600 Fishers Lane
Rockville, Maryland 20852

Holt, Rinehart and Winston, Inc.
383 Madison Avenue
New York, N.Y. 10017

Information, Education, Communication in Population
East-West Communication Institute
Honolulu, Hawaii 96822

Information Materials Press
25 W. 45th Street
New York, N.Y. 10036

International Planned Parenthood Federation
18-20 Lower Regent Street
London, England SW 144 PW

The Johns Hopkins University Press
Baltimore, Maryland 21218

Key Book Service, Inc.
425 Asylum Street
Bridgeport, Conn. 06610

The Lalor Foundation
4400 Lancaster Pike
Wilmington, Delaware 19805

Little, Brown & Company
34 Beacon Street
Boston, Mass. 02106

Martha Stuart Communications, Inc.
66 Bank St.
New York, N.Y. 10014

McGraw-Hill Book Company
330 W. 42nd Street
New York, N.Y. 10036

C. V. Mosby Company
3207 Washington Blvd.
St. Louis, Missouri 63103

Motion Picture Labs, Inc.
781 S. Main St.
Memphis, Tenn. 38102

Multi Media Resource Center
540 Powell Street
San Francisco, California 94108

National Abortion Rights Action League
705 E St. S.E.
Washington, D.C. 20003

National Association for Repeal of Abortion Laws
250 W. 57th Street
Room 2101
New York, N.Y. 10019

The National Audio-Visual Center
Washington, D.C. 20409

National Foundation March of Dimes
P.O. Box 2000
White Plains, N.Y. 10602

New Day Films
267 W. 25th St.
New York, N.Y. 10001

Ortho Pharmaceutical Company
Raritan, N.J. 08869

Outerbridge & Lazard, Inc.
200 W. 72nd Street
New York, N.Y. 10023

Oxford Films, Inc.
1136 N. Las Palmas Ave.
Los Angeles, California 90038

Planned Parenthood Associations of Maryland, Inc.
517 N. Charles Street
Baltimore, Maryland 21201

Planned Parenthood Association of
Southeastern Pennsylvania
1402 Spruce St.
Philadelphia, Pa. 19102

Planned Parenthood Center of Seattle, Inc.
Education Department
202 16th Ave., South
Seattle, Washington 98144

Planned Parenthood Center of Syracuse, Inc.
1120 East Genesee Street
Syracuse, N.Y. 13210

Planned Parenthood League, Inc.
3750 Woodward Avenue
Detroit, Michigan 48201

Planned Parenthood - World Population
810 7th Ave.
New York, N.Y. 10019

Planned Parenthood - World Population
Film Library
267 W. 25th St.
New York, N.Y. 10001

Population Services International
105 N. Columbia Street
Chapel Hill, North Carolina 27514

Prentice-Hall
Englewood Cliffs, N.J. 07632

Prince George's County Health Department
Cheverly, Maryland 20785

Random House
201 E. 50th Street
New York, N.Y.

Regional Training Center for Family Planning
Emory University
The Hartford Building
100 Edgewood Avenue, N.E.
Atlanta, Georgia 30303

Rocky Mountain Planned Parenthood
2030 E. 20th Avenue
Denver, Colorado 80205

Sage Publications
257 S. Beverly Drive
Beverly Hills, Calif. 90212

Martin L. Schwartz
Box 2853
Duke Medical Center
Durham, North Carolina 27706

Charles Scribner's & Sons
Shipping and Service Center
Totowa, N.J. 07512

G.D. Searle and Company
P.O. Box 5110
Chicago, Illinois 60680

Seattle Planned Parenthood
202 16th Avenue South
Seattle, Washington 98114

Sex Information & Education Council of the United States
(SIECUS) Publications
1855 Broadway
New York, N.Y. 10023

Simon and Schuster
630 Fifth Avenue
New York, N.Y. 10020

Society for Humane Abortion
P.O. Box 7562
Long Beach, Calif. 90807

Universe Books
381 Park Avenue South
New York, N.Y. 10016

University of Chicago Press
5750 Ellis Avenue
Chicago, Illinois 60637

U.S. Civil Service Commission
Government Printing Office
Washington, D.C. 20402

John Wiley & Sons, Inc.
605 Third Avenue
New York, N.Y. 10016

Williams and Wilkins Company
428 E. Preston Street
Baltimore, Maryland 21202

World Education
667 Madison Avenue
New York, N.Y. 10021

4.4 Journals and Other Publications

The following sections list publications that emphasize or include articles relevant to clinical and program aspects of family planning. Cost and frequency of publication are noted.

Journals

American Journal of Public Health
American Public Health Association
1015 Eighteenth Street, N.W.
Washington, D.C. 20036
$20.00 per year
Monthly

Contraception
Geron-X Inc.
Box 1108
Los Altos, California 94022
$30.00 per year
Monthly

Demography
The Population Association of America
P.O. Box 14182
Benjamin Franklin Station
Washington, D.C. 20044
$12.00 per year
Monthly

Family Planning Digest
Ms. Faye Richardson
5600 Fishers Lane, Room 12A-27
Rockville, Maryland 20852
To be discontinued 1/75
Back issues available as long as supply lasts.

Family Planning Perspectives
Center for Family Planning Program Development
Planned Parenthood-World Population
515 Madison Avenue
New York, N.Y. 10022
No charge
Quarterly

Journal of Clinical Child Psychology
Suite 208
Meramec Building
111 South Meramec Avenue
Clayton, Missouri 63105

Journal of Marriage and the Family
The National Council on Family Relations
1219 University Avenue, SE
Minneapolis, Minnesota 55414

Journal of Reproductive Medicine
Medical Media Association
34 South Main Street
Mt. Prospect, Illinois 60056
$22.00 per year
Monthly

Ortho Panel, Management of Sexual Problems in Medical Practice
Ortho Pharmaceutical Corporation
Raritan, New Jersey 08869
Upon request

Population Bulletin, PRB Selections
Population Profiles, World Population Data Sheets
Population Reference Bureau
1755 Massachusetts Avenue, N.W.
Washington, D.C. 20036
$5.00 per year
Six times yearly

Reports on Population and Family Planning
The Population Council
245 Park Avenue
New York, N.Y. 10017
Upon request
Irregular

Studies in Family Planning
The Population Council
245 Park Avenue
New York, N.Y. 10017
Upon request
Irregular

Monograph Series

Health Education Monographs
Charles B. Slack, Inc.
Thorofare, New Jersey 08086
$10.00 per year
Quarterly

Monograph Series
Carolina Population Center
University of North Carolina
Chapel Hill, North Carolina 27514
$1.50 per issue

Newsletters

Emko Newsletter
Emko Company
7912 Manchester Avenue
St. Louis, Missouri 63143
No charge
Monthly

Family Plans
Pathfinder Fund
8500 Boylston Street
Chestnut Hill, Massachusetts 02167
Upon request
Irregular

"Focus on the Family" E.C. Brown Center for Family Studies 1802 Moss Street Eugene, Oregon 97403	
Information, Education, Communication in Population East-West Communication Institute 1777 East-West Road Honolulu, Hawaii 96822	Upon request Bi-monthly
Intercom Population Services International 1050 Potomac Street, N.W. Washington, D.C. 20007	$30 per year to organizations $24.00 per year to individuals $18.00 per year to students Monthly
Medical Aspects of Human Sexuality Hospital Publications, Inc. 609 Fifth Avenue New York, N.Y. 10017	$20.00 per year Monthly
Planned Parenthood Report Planned Parenthood-World Population 810 Seventh Avenue New York, N.Y. 10019	
Sex News P.K. Houdek 7140 Oak Kansas City, Missouri 63143	
SIECUS Report Publications Office 1855 Broadway New York, N.Y. 10023	$7.00 per year Bi-monthly

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